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FORCE-FEEDING OF PRISONERS AND DETAINEES ON HUNGER STRIKE

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Right to Self-Determination versus Right to Intervention

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To my parents

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About six years ago, I defended my master's thesis entitled "Food refusal. A legal exploration into the possibilities of force-feeding in cases of food refusal" at Tilburg University. Before that time, I could not have predicted that this thesis would result in the writing of a research proposal, a PhD project and – finally – the appearance of this book. Throughout these years, the question of force-feeding a person who has explicitly stated that he refuses food has never failed to intrigue me and has me provided me with much food for thought.

Although the writing of a PhD thesis would seem to be one of the most solitary experiences possible, I can honestly say that this book would not have been there without the help, support and encouragement of many people in both my professional and my personal life.

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Tilburg, July 2012

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LIST OF ABBREVIATIONS

Biomedicine Convention	the Convention for the protection of human rights and dignity of the human being with regard to the application of biology and medicine
BMA	British Medical Association
CAT	Committee Against Torture
CESCR	Committee on Economic, Social and Cultural Rights
Convention against Torture	Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
CPT	European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
CRC	Convention on the Rights of the Child
D&R	Decisions and Reports of the European Commission of Human Rights
ECHR	European Convention on Human Rights
EComHR	European Commission of Human Rights
ECPT	European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
ECtHR	European Court of Human Rights
EPR	European Prison Rules
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICN	International Council of Nurses
ICRC	International Committee of the Red Cross

ICTY	International Criminal Tribunal for the former Yugoslavia
OHCHR	Office of the UN High Commissioner for Human Rights
PPA	Penitentiary Principles Act (*Penitentiaire beginselenwet*)
PPN	Peripheral Parenteral Nutrition
Principles of Medical Ethics	Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees against Torture, and other Cruel, Inhuman or Degrading Treatment or Punishment
RAF	Red Army Faction (*Rote Armee Fraktion*)
SMR	Standard Minimum Rules for the Treatment of Prisoners
Special Rapporteur on the right to health	Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health
Special Rapporteur on torture	Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment
TPN	Total Parenteral Nutrition
UK	United Kingdom
UN	United Nations
US	United States (of America)
WHO	World Health Organisation
WMA	World Medical Association

INTRODUCTION

He lies there now
Perishing; he is calling against my majesty,
That old custom that has no meaning in it,
And as he perishes, my name in the world
Is perishing also. I cannot give way
Because I am King, because if I give way
My nobles would call me a weakling, and it may be
The very throne be shaken.[1]

1. WHAT IS THIS BOOK ABOUT?

Hunger strikes are not an uncommon phenomenon in places where people are deprived of their liberty. Nevertheless, people who are free often also make use of this form of protest. One of the most well-known examples of this is Mahatma Gandhi, using a hunger strike as a part of his non-violent revolution in his struggle for India's independence from the British. Hunger strikes have occurred throughout the world and many hunger strikes have occurred in the past, having been reported since ancient Roman times. People can have different motives to refuse to take nutrition and/or fluids, but not all sorts of food refusal can qualify as a hunger strike. A decision to refuse food can be the result of a conscious decision, based on personal considerations and circumstances. A (temporary) refusal of food can be a way for a person to lose some extra pounds. Fasting for a longer period can be inspired by religious considerations. People may also refuse food that is not prepared according to their religious beliefs or traditions. In general, such fasting is not health threatening when it is undertaken by otherwise healthy persons. Food refusal can furthermore be an expression of a mental illness or disorder, such as a psychosis, poisoning delusions or major depressive disorder. This is also the case with eating disorders such as anorexia nervosa.[2] Anorexia nervosa is a mental disorder that can result in severe physical damage, and sometimes even cause death. A refusal of

[1] Yeats 1904.

[2] Restellini 2007, p. 37.

food and/or fluids can also be a way to quicken the natural dying process for people who suffer from an incurable illness in the last phase of their lives, or the elderly who desire no further treatment or for whom tube-feeding is no longer desirable.

In all of these cases, people refuse food for certain reasons. But do all these forms of food refusal qualify as a hunger strike? No, they do not. Hunger strikes are specifically meant to reach goals that, in the eyes of the hunger striker, cannot – or can no longer – be achieved otherwise. Hunger strikers expose themselves to extreme starvation (and possibly death) in order to reach certain goals or to express their views or opinions. Sometimes, they underline their resistance by stitching up their mouths,[3] or by also refusing their medication,[4] although fortunately this is rare. Mostly, hunger strikes take place in the public eye and inflict negative publicity on the persons or institutions at which the hunger strike is aimed and which are forced to either bow to the hunger striker's demands, or be seen to be responsible for the hunger striker's possible death.

Because hunger strikes are mostly used by those deprived of certain basic human freedoms, for example refugees and persons who are deprived of their liberty, they are often called the "weapon of the powerless".[5] Refugees and asylum seekers (not being deprived of their liberty) who have exhausted all legal procedures use hunger striking as a means to enforce a revision of their asylum procedure, or as a protest against the handling of the person's immigration case. In this way, they try to prevent being sent back to their country of origin. These people are often very desperate and even prepared to give their lives as a final consequence of their action. The feeling that they have nothing to lose is frequently a decisive factor.

Another specific group are those who go on hunger strike whilst being deprived of their liberty. This study is focused on the specific situation of prisoners and detainees on hunger strike.

In cases of prisoners and detainees on hunger strike, the dilemma between, on the one hand, the responsibility of the State and caretakers involved for the health of the hunger striker and other third parties' interests that may plead in favour of force-feeding, and, on the other hand, the individual right to self-determination of the prisoner and detainee, derived from fundamental values as autonomy and human dignity is most intense. Because hunger strikes mainly give rise to dilemmas in settings where people are deprived of their liberty, I have chosen to focus on

---

3 Such as the prisoners on hunger strike in Kyrgyzstan, protesting against their conditions of imprisonment, in January 2011. <http://www.trouw.nl/tr/nl/4496/Buitenland/article/detail/3136420/2012/01/24/1000-gevangenen-in-Kirgizie-naaien-mond-dicht.dhtml> (last accessed on 27 January 2012).

4 Ad van den Berg, president of the Dutch paedophile party, in April 2011 was on hunger strike for ten days in protest against his arrest. Besides refusing food, he, being diabetic, also refused insulin injections. <http://www.ad.nl/ad/nl/1012/Binnenland/article/detail/2424641/2011/04/07/Voorzitter-pedovereniging-Martijn-stopt-hongerstaking.dhtml> (last accessed on 11 March 2012).

5 Johannes Wier Foundation 1995, p. 1.

this special group of people. Prisoners and detainees often use a hunger strike as a form of protest, to affect some change, to enforce wishes and demands (such as a transfer to another prison or other place of detention, or a change in the custodial circumstances) or to obtain perceived or actual rights. For many prisoners and detainees, a hunger strike is their only weapon, when they lack, or have exhausted, all other possibilities of protest. It is often the only way left to protest against or demand attention from the authorities involved.

As will be demonstrated in Chapter 1, a hunger strike can cause serious damage to the hunger striker's body. When the hunger strike is prolonged, the government, but also prison officials, physicians, and nursing staff, can feel a particular urge – for a diversity of reasons – to intervene in the hunger strike through the use of force-feeding.

2. REASONS FOR RESEARCH AND THE RESEARCH QUESTION

Historically, States and their authorities have responded differently to hunger strikes. Suffragettes in the United Kingdom (hereafter: UK) at the beginning of the twentieth century, and for many years after, were force-fed while on hunger strike. On the other hand, many countries, such as the Netherlands, have long emphasised the prisoner's and detainee's right to self-determination and refrained from intervention in hunger strikes.[6] Nowadays, views of the permissibility of force-feeding, as illustrated in international and European declarations on the subject, as well as the views of countries worldwide, but also within Europe, of the permissibility of force-feeding on a national level, still vary enormously. No consensus exists as to the outcome of the conflict between a prisoner's or detainee's right to self-determination and other arguments put forward in favour of force-feeding.

Hunger strikes are often not only a legal and medical-ethical problem, but even more a political or social problem. The societal context in which the hunger strike takes place is of great importance. Hunger strikes often have a significant impact on society and on the family of the hunger striker. In many cases, they generate much media attention, fierce debates, and turmoil. Hunger strikes are often considered to be manipulative efforts by detainees. In many cases, hunger strikes have nonetheless shown to be a powerful means to put pressure on officials, organisations and governments. Since the twentieth century, hunger strikes have increasingly been used as a political tool. The cases of Volkert van der G. in the Netherlands, Iñaki de Juana in Spain, and prisoners in Guantánamo Bay show that (inter)national politics can be seriously impacted by hunger strikes. Although it is difficult to

[6] The historical development and current policy on force-feeding hunger strikers in the Netherlands and England and Wales is described in Chapter 6.

accurately enumerate the prevalence of hunger strikes in prison, often caused by a lack of any systematic monitoring, cases of hunger strikes involve situations in which fundamentally compelling interests conflict. Moreover, hunger strikes can not only draw the attention of the media and induce highly charged societal and political debate, but can also severely challenge legal systems as well as policies on hunger strike. It is therefore important to provide clarity on the question of how the right to self-determination relates to arguments in favour of force-feeding, and whether the use of force-feeding of prisoners and detainees on hunger strike can be justified from a legal and medical-ethical perspective.

The issue of force-feeding hunger strikers is not new in the literature. Nevertheless, publications on the topic focus to a large extent on the medical-ethical aspects. Where authors have paid attention to the legal aspects of the matter, they mainly concentrate on the legal framework for the assessment of force-feeding in the United States (hereafter: US).[7] An in-depth study into the human rights aspects of the issue of force-feeding prisoners and detainees on hunger strike from a European and international perspective is, as yet, sorely lacking. The legitimacy of force-feeding in this study will be explored in the light of the case law of the different Courts and other relevant international documents. This international dimension is of growing importance because of the increasing power of the European Courts and European legislative institutions, combined with the process of European integration and harmonisation. The European perspective of this research is furthermore reflected in the jurisdictions that are studied in more detail on a national level, i.e. the Netherlands, Germany, and England and Wales. Although this research mainly focuses on the legal aspects of the question of force-feeding hunger strikers, it also takes into account the medical-ethical aspects of the issue, which form an indispensable – but also complicating – element in the debate on the legitimacy of force-feeding.

The central research question is as follows:

> Can the use of force-feeding of prisoners and detainees on hunger strike be justified from a legal and medical-ethical perspective? If so: in what cases and under what circumstances?

3. MEDICAL (LAW) APPROACH OR HUMAN RIGHT APPROACH?

In Chapter 6, national policies on force-feeding in the Netherlands, Germany, and England and Wales will be discussed. As demonstrated there, in England and Wales the medical law approach was adopted in the 1995 case of *R v Home Secretary,*

[7] See, for example, Tagawa 1983, Silver 2005 and Ansbacher 1983.

ex parte Robb.[8] The discussion on the use of force-feeding in England and Wales seems to have been resolved by considering the question of force-feeding as a purely clinical matter that is to be decided by a physician. In this medical (law) approach, prisoners and detainees are treated no differently than persons in the outside world, and as a result they enjoy the same right to refuse medical treatment, even when this decision may result in their death. The adoption of the medical (law) approach to the matter of force-feeding prisoners on hunger strike has been criticised in the literature, among others by Kennedy, who argues that it should not be applied to prisoners, as according to her,

a) the principle that a person's body *prima facie* is inviolate does not identically apply to prisoners as it applies to persons in the outside world, since they "may in appropriate circumstances be manhandled" and

b) the medical approach is concerned with "patients" who refuse "treatment", and not with hunger strikers who consciously decide to refuse food.

Also, according to her, it is not clear why the application of food and water should be regarded as treatment in the context of a hunger strike.[9]

Here, I will only go into the issue advanced by Kennedy as illustrated under b) (the point under a) will be discussed in Ch. 3, § 4). This point refers to the discussion of whether the issue of force-feeding should be approached from a medical (law) perspective. In my opinion, although this approach is not chosen in this study, the issue of hunger strike can in fact be approached from a medical (law) perspective. Although a prisoner or detainee who goes on hunger strike may have no significant medical problems at the start of his actions, as the hunger strike is prolonged his physical deterioration will inevitably require medical intervention in order to preserve his life. As will be demonstrated in Chapter 1, force-feeding is a medical intervention that is to be performed by health professionals, and requires an assessment of the medical necessity and an assessment of the risks of such intervention in an individual case. But even when the physical deterioration has not progressed to such an extent that medical intervention is required to preserve the hunger striker's life, or it is clear (for example, because this is standard policy or it is legally not possible) that no forced medical treatment to preserve the hunger striker's life will be performed, medical assistance will be needed in the counselling of the hunger striker and the supply of information to him, including regarding the consequences of his decision, and the possibilities to minimise physical harm, starting from the beginning of the hunger strike. The hunger striker will be asked at the beginning of his actions for his consent to certain medical treatment. As with preventive medicine, a person's consent for certain medical treatment (for example,

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8 *R v Home Secretary, ex parte Robb* [1995] 1 All ER 677. See Ch. 6, § 4.6.

9 Kennedy 1995, p. 190.

vaccinations) is required. As will be shown in this research, it is a basic principle that persons (thus not only patients) need to consent before medical treatment can be administered. Besides, hunger strikes in prison are so much interwoven with medical aspects and counselling, that health care professionals almost automatically play an important, if not crucial, role in hunger strikes. This conclusion is not invalidated by the fact that the physical harm is self-inflicted, caused by the decision to refuse food. Accordingly, in my opinion, the medical (law) approach can in fact be used to govern the situation of prisoners and detainees on hunger strike, and the question of forced medical intervention.

Answering the research question of the legitimacy of force-feeding of prisoners and detainees on hunger strike is dependent on the approach chosen. Although the basic principle for competent prisoners and detainees on hunger strike is concurrent in both approaches, the medical (law) approach does not acknowledge exceptions to the rule, while such exceptions can be formulated on the basis of the human rights approach. Although I acknowledge that the medical (law) approach in England and Wales can provide a workable approach to the treatment of prisoners and detainees on hunger strike, it fails to take into account important obligations and interests that oppose an absolute right to refuse food for prisoners and detainees, most notably the State's desire to intervene to preserve the hunger striker's life on the basis of their duty to care for people who they have deprived of their liberty. Moreover, in the medical (law) approach no third parties' interests that may argue in favour of intervention are taken into account. These State's obligations and third parties' interests considerably complicate the question as to whether the hunger striker's wishes should be absolutely respected, or whether his wishes can be overruled by other prevailing interests, which, in my opinion, in certain circumstances can be the case (see Ch. 7, § 5). In my opinion, these legal obligations and interests form an indispensable part of the dilemma in deciding whether to force-feed, and for this reason the more comprehensive human rights approach is to be preferred. In this human rights approach, these legal obligations and interests opposing an absolute right to refuse food are also taken into account when considering the question of whether the force-feeding of prisoners and detainees on hunger strike be justified.

Although I acknowledge that medical aspects can play an important role in deciding whether to force-feed, I do not agree with Van Zyl Smit and Snacken who conclude that "at the European level the approach to hunger strikes predominantly has been to view them as medical problems that should be primarily dealt with by medical doctors", referring to case law of the European Commission of Human Rights (hereafter: EComHR), the European Court of Human Rights (hereafter: ECtHR), the findings of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (hereafter: CPT) and the Recommendation of the Committee of Ministers of the Council of Europe in the context of hunger strikes in prison and other places of detention (all of which will be

discussed in Chapter 5).[10] Indeed, the ECtHR has consistently attached great value in its case law to the medical aspects of force-feeding when assessing its conformity with the rights as codified in the European Convention on Human Rights (hereafter: ECHR), and also – even more – the CPT does so in its reports on individual cases (see Ch. 5, § 3.4 and 3.5). Still, in my opinion, these medical facts are mainly used by both organs as a framework of reference in an individual case to assess whether force-feeding a prisoner and detainees on hunger strike constitutes a violation of the rights as laid down in the ECHR, most notably the prohibition of torture or inhuman or degrading treatment or punishment under Article 3 ECHR. (I will use the term "ill-treatment" to cover the terms prohibited under Article 3 ECHR in this research.)[11] As will be explained in Chapter 5, the ECtHR has left a wide margin of interpretation to the Council of Europe Member States to decide on the issue of force-feeding prisoners and detainees on hunger strike. When Member States decide to impose force-feeding on hunger strikers, the ECtHR and CPT can be asked to assess its conformity with ECHR rights in individual cases.[12] In such cases (see, for example, the *Nevmerzhitsky* case as elaborated on in Ch. 5, § 3.4.6), the ECtHR was confronted with a decision to apply force-feeding, taken by national authorities. In these instances, the ECtHR does not answer the fundamental question of the legitimacy of this decision, as it accepts that force-feeding hunger strikers can be legitimate, but only assesses its conformity with ECHR rights, such as the prohibition of ill-treatment under Article 3 ECHR. Medical and also procedural aspects, in this respect, are used to investigate in concrete terms whether the decision to apply force-feeding is the result of a careful decision-making process, and to investigate the question as to whether the force-feeding was medically necessary and applied as humanely as possible. In this way, medical and also procedural facts of the case serve as a framework of reference to assess whether force-feeding a prisoner and detainees on hunger strike constitutes a breach of their rights as safeguarded under the ECHR. The same goes for the CPT, when investigating whether force-feeding in an individual case constitutes ill-treatment. For this reason, I do not agree with the position held by the ECtHR that hunger strikes are medical problems that should be primarily dealt with by medical doctors. Also, the "full and uncritical referral to the Declarations of the WMA [the World Medical Association, the global representative body of physicians]" in the ECtHR's case law in my opinion does not bring about that established principles of medicine require a doctor not to intervene in the case of a competent hunger striker, as Van Zyl Smit and Snacken state.[13] In my view,

10 Van Zyl Smit & Snacken 2008, p. 167.

11 Cf. the terminology as used by the CPT, see Ch. 3, § 6.2.2.2.

12 Although their role and mandate in investigating alleged violations under Article 3 ECHR differs, see Ch. 5, § 3.5.1.

13 See, for example, Van Zyl Smit & Snacken 2008, p. 170.

the referral to the declarations by the WMA[14] only shows that the ECtHR has had due regard to these authoritative documents in the area of hunger strike in prison, but it does not mean that the ECtHR adopts the WMA approach to force-feeding. After all, the ECtHR in the cases involved does not refer to these Declarations in the substance of the case, but only mentions them in summing up relevant documents in the field of hunger strikes. Moreover, the ECtHR's final conclusion on the legitimacy of force-feeding of competent hunger strikers is completely opposed to the position described in the WMA Declarations of Tokyo and Malta, as will be demonstrated in this study in Chapter 5.

Although I acknowledge that the medical approach, viewing hunger strikes as medical problems that should be dealt with by medical doctors, would be far more easily reconciled with the medical-ethical posture as adopted by the WMA, the more comprehensive human rights approach is to be preferred, since, as stated above, legal obligations by States and third parties' interests form in my opinion a complicating, but indispensable part of the dilemma in deciding on force-feeding. In my opinion, there is no such thing as *the* hunger striker, and every individual hunger strike requires a careful consideration of all the rights and interests involved.

4. DELINEATION

As noted above, the question concerning the use of force-feeding in hunger strikes involves important ramifications, both legal and medical-ethical. Nevertheless, the medical-ethical elements of force-feeding prisoners and detainees on hunger strike will only be discussed when the legitimacy of the use of force-feeding on the physician's level is investigated. The physician's medical-ethical considerations are mostly codified in documents such as guidelines, recommendations and declarations, and therefore suitable for study by a legal researcher. Besides, this research focuses on the human rights aspects of the question of force-feeding and leaves the ethical questions to the matter unanswered.

5. STRUCTURE OF THE BOOK

The central research question is divided into several sub-questions. Each sub-question will be discussed in one or more chapters.

1. What are the physical consequences of a hunger strike and how can intervention take place?

[14] More on the WMA, its history, members, aim and objectives, see Ch. 5, § 2.2.

The first chapter starts with an elaboration on the definitions used in this research, *inter alia*, what constitutes a hunger strike. The generally accepted views in the medical world on the physical consequences of a hunger strike are described next. Relevant questions in this respect are: how long can a hunger strike continue, when does irreversible physical damage occur, and in what ways is it possible to intervene?

2. What are the meaning and scope of the underlying concepts in the discussion on force-feeding: personal autonomy, the right to self-determination and informed consent? Do these rights and concepts apply to prisoners and detainees in full?

When the question of force-feeding arises, the hunger striker's personal autonomy, the right to self-determination and informed consent collide with other arguments in favour of force-feeding. Before exploring this collision in depth in the next chapters, I will explore the meaning and scope of the underlying concepts in the discussion in Chapter 2: the concept of personal autonomy, the right to self-determination and informed consent in the medical context. In Chapter 3, I will explore these notions for prisoners and detainees. These notions are explored in particular in relation to the question of whether they can be limited, and if so, on what grounds.

3. What are the pros and cons of the use of force-feeding in cases of prisoners and detainees on hunger strike?

As stated before, in the case of force-feeding, the hunger striker's right to self-determination and the interests of other parties collide. To investigate the question of whether the use of force-feeding can be legitimate and, if so, in what cases, it is essential to have a clear overview of all the relevant interests at stake. A list of the arguments in favour and against force-feeding is made in the Chapter 4.

4. How do the European Court of Human Rights and other international organisations assess the legitimacy of the use of force-feeding?

The way in which the pros and cons of the use of force-feeding as set out in Chapter 4 are assessed in international and European documents and case law on force-feeding prisoners and detainees on hunger strike is studied in Chapter 5. Furthermore, in this chapter, relevant international documents (treaties, recommendations, declarations, etc.) and case law concerning the treatment of prisoners and detainees on hunger strike will be elaborated upon.

5. How do the Netherlands, Germany, and England and Wales deal with the matter of force-feeding in cases of hunger strike in their national legislation and case law?

After having formed a picture of the possibilities concerning the use of force-feeding as reflected in international and European documents and case law in Chapter 5, the national legal situation on force-feeding prisoners and detainees on hunger strike will be assessed for three different jurisdictions: the Netherlands, Germany, and England and Wales. In these three jurisdictions, the matter of force-feeding has been (or still is) the subject of discussion and debate, and each of these jurisdictions has its own history and particular viewpoint on the legitimacy of the use of force-feeding. Not only the current viewpoint, but also the development of this viewpoint and the influence of particular cases on the policy towards the treatment of hunger strikers, will be taken into account.

After every chapter, I will summarise the main findings in its conclusions. The findings of the first six chapters will be used in the synthesis of Chapter 7, answering the final research question of whether the use of force-feeding of prisoners and detainees on hunger strike can be justified from a legal and medical-ethical perspective, and if so, in what cases and under what circumstances?

6. METHODOLOGY

The methods used in this research are the "traditional" methods used in legal research: the study of relevant legislation, literature and case law. To this end, a variety of sources was used, comprising, inter alia, legislation and legislative history, case law (from national as well as international bodies), policy documents and other legal documents. As stated above, I will only elaborate on the medical-ethical aspects of the issue as far as they are laid down in documents such as guidelines, recommendations and declarations.

For this research, both legal and medical-ethical literature has been used. The course of a hunger strike, its consequences, and the ways to intervene as illustrated in Chapter 1 are (largely) described in medical literature. This medical information is relevant for this study, as it also strongly influences the legal and medical-ethical considerations. Still, as a legal researcher I have limited myself to an elaboration on the generally accepted views in the medical world on these subjects as illustrated in medical literature. For a further elaboration on these aspects I refer to the sources as mentioned in this chapter.

Besides the study of legislation, literature and case law, I have also held interviews with national and international experts in the field of hunger strikes. These experts included legal experts as well as medical experts. Additionally, interviews were held with physicians who have treated hunger strikers in practice and persons who have experienced hunger strikes on account of their position as, inter alia, prison

governors or spiritual counsellors.[15] I also interviewed a prisoner who underwent a long-term hunger strike himself.

In Chapter 6, the views on force-feeding of prisoners and detainees on hunger strike in the Netherlands, Germany, and England and Wales are explored. This does not contain an exhaustive comparative research of the three jurisdictions involved, but it is used to explore the arguments for and against force-feeding, and to investigate how the matter is actually dealt with on a national level. The historical development of policies on force-feeding was described by remarkable cases that have influenced or were the expression of a certain development in thinking about force-feeding. A study of England and Wales excludes Scotland and Northern Ireland, the other parts of the UK. Although parts of the legal system are common to the whole of the UK, many parts are separate for each jurisdiction. Two of the jurisdictions of the UK have intense experience in dealing with hunger strikes, i.e. Northern Ireland and England and Wales.[16] In Chapter 6, past and current policy on force-feeding prisoners and detainees on hunger strike in the biggest jurisdiction, England and Wales, is investigated. Where conclusions can be drawn for the whole of the UK, including Scotland and Northern Ireland, this is explicitly indicated.

Most literature was found in the library of Tilburg University (Tilburg, the Netherlands), Maughan Library of King's College London and the library of the International Centre for Prison Studies (both London, the United Kingdom), and the library of the Max Planck Institut für ausländisches und internationales Strafrecht (Freiburg im Breisgau, Germany).

15 Details of these interviews as well as names of the interviewees are on file with author.

16 Sweeney has elaborated on the history of Northern Irish hunger strikes: Sweeney 1993.

CHAPTER ONE

PRISONERS AND DETAINEES ON HUNGER STRIKE

1. INTRODUCTION

In this chapter, the definitions as used in this study will first be explored. Secondly, I will go into the difference between a hunger strike and suicide and euthanasia. Thirdly, I will briefly discuss "on and off" hunger striking. Fourthly, the physical consequences of a hunger strike will be explored. Fifthly, I will elaborate on recovery after a hunger strike. Sixthly, I will deal with death as a result of a hunger strike. Seventhly, I will go into the different procedures of force-feeding and artificial feeding. Eighthly and finally, I will offer conclusions.

2. DEFINITIONS

For a correct understanding of the terms used in this research, I will explore the definitions of the most important terms below.

2.1. PRISONER, DETAINEE AND CUSTODY

In the literature, as well as in international and European documents different definitions of the terms "prisoner" and "detainee" are used to denote groups of persons who are deprived of their liberty. There is no consensus on what determines which groups of persons that are deprived of their liberty can be classified as prisoners or detainees, and which groups are excluded from these definitions. In this multitude of definitions I will use my own definition of prisoner and detainee.

In this research, the term "prisoner" refers to persons who are deprived of their liberty in connection with a suspected or proven criminal offence. This category of persons thus, *inter alia*, includes suspects in police custody, persons in pre-trial custody and persons who are sentenced to imprisonment following a criminal

conviction. All of these groups find themselves in prison because of the workings of the criminal justice system. Because of this "penal connotation" a different term will be used for persons that are deprived of their liberty, but who are not connected with a suspected or proven criminal offence. I will use the term "detainee" to refer to the group of people who are deprived of their liberty except as a result of a suspected or proven criminal offence. Detainees are, *inter alia*, persons that are deprived of their liberty by a civil judge and the administrative judge, persons who are compulsorily admitted to a mental hospital or persons who are detained in a detention centre for irregular migrants or asylum seekers. Besides these differences, one key element remains the same: both prisoners and detainees are deprived of their liberty by a competent authority and find themselves in custody. Where I refer to "persons in custody" both prisoners and detainees are meant.

Where the term "prisoner" is used in international and European documents, in most cases it is used as an "overall" term to cover the wider group of persons in custody. Where relevant for determining the applicability of these document to the different kinds of groups of people that are deprived of their liberty, I will briefly go into the definition of the terms as used in the document at hand in the chapters concerned.

2.2. PRISON AND OTHER PLACE OF DETENTION

When in this research the term "prison" is used, this refers to the place where prisoners are held. Detainees are detained in what I refer to as "other places of detention" because of a placement order in a closed institution, such as reception centres for asylum seekers, removal centres, psychiatric institutions and places where young persons are deprived of their liberty. When in this research the term "in custody" is used, it refers to all institutions where persons are deprived of their liberty by a legal authority, i.e. prisons and other places of detention.

2.3. PHYSICIAN AND DOCTOR

When in this research the term "physician" or "doctor" is used, these terms refer to a person who is licensed to practise medicine. The terms will be used interchangeably. Although the role of the physician and doctor and the meaning of both terms may vary around the world, for the purposes of this research I will use the term physician and doctor to indicate the medical professional in the widest sense, covering both medical specialists (such as surgeons or specialists in internal medicine) and general practitioners (such as family practitioners). Not only physicians and doctors, but also psychiatrists, nurse practitioners, paramedics, physicians' assistants and other health care professionals are likely to be involved and play a significant role in the treatment of hunger strikers. However, while international documents containing

medical-ethical rules and principles are often only addressed to physicians or doctors, in my opinion these documents also form valuable guidelines for other health professionals involved in the treatment of hunger strikers. When ethical codes or declarations exist that specifically apply to special groups of health professionals such as nurses, these codes and declarations will be explicitly mentioned and commented upon.

2.4. FORCE-FEEDING AND ARTIFICIAL FEEDING

Force-feeding can be used to intervene in a hunger strike to preserve the health and life of the hunger striker. Force-feeding means that medical treatment is administered by which the hunger striker is compelled to ingest food. In case law and the literature, force-feeding is also referred to as forcible feeding, compulsory feeding or artificial feeding.

Although these terms in the literature and case law are often used interchangeably and are often seen as synonymous, there is a difference between force-feeding and compulsory feeding on the one hand, and artificial feeding on the other. All force-feeding is artificial, but not all artificial feeding is forced. Force-feeding and compulsory feeding imply coercion, and suggest that the feeding is involuntary and is performed under duress. Artificial feeding, however, need not involve coercion. Artificial feeding can be a solution for food refusers who do not want to endanger their health but who refuse to take nourishment normally for reasons of their own. In this case, the food refuser consents to his treatment. The term artificial feeding can nevertheless also be used when the hunger striker is no longer fully conscious and too weak to express a view, and to oppose to his treatment.[1] The feeding in these cases is sometimes not desired by the hunger striker, but because of his unconscious or non-competent state he is no longer able to actively resist being fed.

In this research, the term "force-feeding" will be used to indicate that feeding is applied against the express wishes of the person involved. As will be shown later on, feeding a prisoner or detainee on hunger strike will almost always require force to restrain him. In the situation in which the prisoner or detainee is no longer able to actively resist his treatment because of his unconsciousness or his incompetence, it will be referred to as artificial feeding.

In § 8 of this chapter, I will elaborate on procedures of force-feeding and artificial feeding, the use of force and medical risks. As will be shown there, both force-feeding and artificial feeding require medical intervention. For this reason, in this research I will refer to force-feeding and artificial feeding as medical intervention. Nevertheless, force-feeding and artificial feeding can also be (part of the) medical treatment of a person who refuses food to preserve his health and life. Most hunger

[1] WMA 2006, pp. 40-41.

strikers refuse all medical treatment that is against their wishes, most notably the application of feeding. For this reason, where I refer to hunger strikers who refuse *medical treatment* in this research, medical treatment against their wishes is meant, which includes in particular force-feeding.

2.5. HUNGER STRIKE AND FOOD REFUSAL

As stated in the introduction to this book, although persons who are free sometimes also decide to begin a hunger strike, this research only focuses on hunger strikes by prisoners and detainees.[2] In custody, the tension between intervention through the use of force-feeding and respect for the decision of the hunger striker to refuse treatment reaches its acme and takes on an additional dimension. As Reyes notes:

> "The element of coercion in custodial situations, whereby the prison authorities have to define their position vis-à-vis a form of protest that is most likely to be against the internal rules, possibly even against the law of the land, substantially complicates the issue. This is particularly true in countries where individual rights, or even human rights in general, are perhaps not fully respected."[3]

But what defines a hunger strike? In the literature, but also in international and European documents on the subject, many different definitions are used to define a hunger strike. Hunger strikes are often called "voluntary total fasting". The WMA[4] in its glossary in the Background Paper on the Declaration of Malta, in reference to the term "voluntary total fasting" notes that fasts in detention are seldom total and participation can also be more coerced than voluntary, particularly in extended collective hunger strikes.[5] Until 2006, the WMA in its Declaration of Malta defined a hunger striker as a "mentally competent person who has indicated that he (or she) has decided to refuse to take food and/or fluids for a significant interval".[6] In several documents, precision has been added to the duration of the food refusal to qualify as a hunger strike. In the Background Paper on the Declaration of Malta, the WMA excludes short-lived fasts which peter out within 72 hours from the

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2 Although the vast majority of hunger strikers are male, both men and women can be hunger strikers. When I refer to prisoners in this book, "he" and "his" should be read as including "she" and "her(s)".

3 Reyes 1998.

4 More on the WMA, its history, members, aim and objectives; see Ch. 5, § 2.2.

5 WMA 2006, pp. 37 and 42

6 WMA Declaration on Hunger Strikers. Adopted by the 43rd World Medical Assembly in Malta, November 1991. Editorially revised at the 44th World Medical Assembly in Marbella (Spain), September 1992. Revised by the WMA General Assembly in Pilanesberg (South Africa), October 2006. After the revision of 2006, this definition was removed from the Declaration.

definition of a hunger strike, because this short-term rejection of food rarely gives rise to ethical dilemmas as health is generally not permanently damaged as long as fluids are accepted. The definition of a hunger strike thus only refers to hunger strikes that last longer than 72 hours. The WMA's definition of "hunger strike" refers to protest fasting without any intake of food, but with ingestion of adequate quantities of water.[7]

Besides the WMA's definition, many more definitions of hunger strike exist. I have developed my own definition of hunger strike that consists of four central elements. In this research, the term hunger strike is defined as a *determined effort* by a *mentally competent person* who has indicated that he *refuses food* as a *form of protest*. These elements must all be fulfilled – if one of these elements (such as competence) is lacking, a refusal of food can only be qualified as such, and cannot be considered a hunger strike. For this reason, where I deal with food refusal by incompetent prisoners and detainees in this study, I will refer to this action as a food refusal, instead of referring to it as a hunger strike. I will elaborate on the four different elements of the definition of hunger strike as used in this research below.

2.5.1. Hunger strike as a determined effort

First of all, the definition states that a hunger strike must be undertaken as a determined effort. Not all food refusal qualifies as a hunger strike and causes legal and medical-ethical dilemmas. Some documents, both international, such as the WMA's definition as described above, and national, such as custodial authorities' time limits, are used to determine what qualifies a hunger strike. Some see the duration of food refusal as a key defining factor in determining whether it qualifies as a hunger strike. In my opinion, however, it is not so much the duration of food refusal that is decisive in determining whether a hunger strike qualifies as such, but the determination of the hunger striker. The determination of the hunger striker is often closely related to the motives behind the hunger strike. Prisoners and detainees can have different motives to go on hunger strike. Intentions, motivations and the food refuser's determination can differ greatly and may require different responses to their actions. Different authors have categorised sorts of food refusal and hunger strikes, based on their motives. Williams, in addition to Bennett,[8] categorises the different types of hunger strike as shown in Table 1.[9]

Williams concludes that the State has a duty to intervene in category 4 hunger strikes. According to him, if it is known that a certain prisoner or detainee may engage in self-mutilation or suicide while he is in custody, it is the State's duty to take reasonable care to prevent the prisoner or detainee from engaging in these

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7 WMA 2006, p. 36.

8 Bennett 1983.

9 Williams 2001, p. 287.

Table 1: Williams' categories of hunger strike

1. Strikes relating to frustration	– to draw attention to political or other beliefs – a determined effort to pursue action to the end – a hope that demands will be met and they can resume nutrition – death is a possibility, although not the objective
2. Strikes intended to gain attention	– typically of short duration – no intention to pursue it to the end – lack of clear conditions for ending action
3. Strikes used as a bargaining tool	– action is one of a set of complex negotiation about, for example, prison life – lacks the uncompromising approach of category 1 – will be compromised by a "reasonable offer" – if no offer made, it will eventually be abandoned
4. Strikes with rational or irrational suicidal aims	– prisoner may have already expressed the wish to die but lacks alternative means of committing suicide – death is the desired objective
5. Nutrition refusal for medical reasons	– prisoner suffering from eating disorder – such as anorexia – […]

acts, so that he remains free from harm until he is set free. This duty exists if a risk of self-mutilation or suicide exists, irrespective of whether the prisoner or detainee involved is mentally disturbed or of sound mind.[10] Categories 2 and 3 present less serious problems as they represent short-term action taken by the prisoner or detainee and are not a serious threat to life.

In his article, Williams pays no further attention to the fifth category. Besides prisoners suffering from eating disorders, such as anorexia, as mentioned by Williams in the fifth category, it has been noted by Restellini that also somatic problems, such as dental problems, ulcers, obstructions of the digestive tract, very poor general health and fever, may cause the prisoner or detainee to stop eating.[11] The result of such an action can be that the prisoner or detainee refuses to eat for a period of time, as a hunger striker does. Under the definition of the WMA, the refusal of

[10] Williams here refers to Lord Hope's statement in the ruling by the House of Lords in *Reeves v Commissioner of Police of the Metropolis* ([1999] 3 All ER 897).

[11] Restellini 2007, p. 37.

nutrition for medical reasons can be qualified as a hunger strike. In my opinion, a refusal of nutrition for medical reasons, however, is completely different from a hunger strike. Cases of nutrition refusal for medical reasons should be handled as medical cases, by providing the necessary medical treatment, and should not be considered as hunger strikes. Williams seems to be of the same opinion, as he uses the term "nutrition refusal" in the definition of the fifth category, whereas he uses the term "strikes" in the definition of the other four categories.

Williams points out that category 1 cases give rise to ethical and legal issues, which call for a discrete approach that balances the prisoner's or detainee's right to autonomy with interests the State may have in preserving life or allowing the prisoner or detainee to die. He notes furthermore, that placing the actions of a prisoner or detainee within one of the categories can be very difficult, because there is scope for overlap between the different categories, and rhetoric and intention can be entangled.[12]

The WMA, in its Background Paper on the Declaration of Malta, distinguishes two main categories of individuals that embark on hunger strikes. The first category resembles Williams' second category of hunger strikers. The WMA describes this category as "food refusers that fast to gain publicity or to achieve their goals, but have no intention of permanently damaging their health". This resembles the group of persons that Reyes defines as "reactive food refusers" (he does not regard these persons as hunger strikers): persons who refuse food in reaction to some event, with no particular strategy or intention to pursue it for a longer period.[13] The WMA notes that their goal behind the food refusal may seem relatively petty, but may also involve reasons of principle. When this kind of hunger strikes is repeated a couple of times, it may be experienced as a form of blackmail by the authorities, who may decide to let it continue to test the protesters' resolve. This category of hunger strikers do not wish to die and may often agree to artificial feeding being provided at some stage and may actually request medical assistance in monitoring their fast.[14] These hunger strikes, similar to Williams' second category, are intended to gain attention and the hunger strikers have no intention to pursue it to the end.

The second category distinguished by the WMA is that of what might be seen as very determined hunger strikers who are not prepared to back down unless their goal is actually attained. These hunger strikers are determined to risk their health or lives for a certain cause. According to the WMA, such hunger strikers pose a serious challenge to medical ethics, as their willingness to take fasting to the extreme inevitably raises difficult questions about whether and when to intervene, and force-feeding can be justified.[15] This group of hunger strikers resembles Williams'

12 Williams 2001, pp. 286-287.

13 Reyes 1998.

14 WMA 2006, p. 37.

15 WMA 2006, p. 37

first category. These hunger strikers are determined to pursue their action to the very end, and although death is not the objective, it can be the end result of their action.

In my opinion, only this last category qualifies as hunger strikers. Food refusals by not so determined persons will mostly not raise major ethical problems, as the question of force-feeding will not arise. A hunger striker, by contrast, is in fact committed to long-term food refusal, and will take the risk of endangering his health and life. These hunger strikers strike as a determined effort to draw attention to their political or other beliefs (or personal demands). They often, but not by definition, have political motives, such as the hunger strikers in Turkey in 2000/2001, hunger strikers De Juana in Spain in 2007 and Šešelj before the Yugoslavia Tribunal.[16] The question of force-feeding in these cases will be most significant. In my definition, only food refusers who are determined, and not prepared to back down unless their goals are attained qualify as hunger strikers. The determination of the hunger striker will strongly influence the course of the hunger strike and the medical consequences of his action. Physicians should therefore continuously ascertain his wishes from the beginning of the hunger strike. This is not only necessary to determine the medical reaction, but also for determining the legal response to his actions.

2.5.2. Competence

Secondly, according to the definition as used in this study, a hunger striker must be mentally competent. As already mentioned, the Declaration of Malta explicitly refers to the mentally competent hunger striker. The guidelines for the management of hunger strikers, under point 9, clearly state that: "Individuals with seriously impaired mental capacity cannot be considered to be hunger strikers. They need to be given treatment for their mental health problems rather than allowed to fast in a manner that risks their health." Definitions used by other authors mostly also include the fact that the hunger striker has to be mentally competent.[17] The same goes for the definition of a hunger striker as used in this research. As stated earlier, only competent prisoners and detainees qualify as hunger strikers. If an incompetent person decides to refuse food, he is referred to as a food refuser. The tension between the right to self-determination of the competent prisoner or detainee and other conflicting interests is the strongest, because the refusal of food and/or fluids in this case is a clear and conscious decision. The assessment of competence also plays an

[16] For the last two cases, see respectively Ch. 5, § 3.5 and 2.1.9.

[17] See, for example, Oguz & Miles 2005. They define a hunger strike as "an action in which a person or persons with decision making capacity (often, but not always, in prison) refuses to ingest vital nourishment until another party accedes to certain specified demands". Reyes also states that "[f]asting prisoners who are mentally ill or otherwise incapable of unimpaired rational judgement and decision-making cannot be considered real hunger strikers, whatever their own claims" (Reyes 1998).

important role in determining the possibilities for forced intervention in a hunger strike or food refusal. I will elaborate on the issue of competence in Ch. 2, § 6.

2.5.3. Refusal of food – difference from thirst strike

Thirdly, according to the definition, a hunger strike includes a refusal of food, but not fluids. The complete refusal of fluids is called a thirst strike (sometimes also called a "dry (hunger) strike" or "dry fasting"), and can only be maintained for four to ten days, depending on different factors such as ambient temperature and humidity, and the hunger striker's level of stress and physical activity.[18] Serious health problems already occur after two to four days.[19] Death of the thirst striker is usually caused by alterations in the cardiac rhythm.[20] A thirst strike is very hard to carry out because of the rapid dehydration of the body. Refusal of both food and water is uncommon, because it usually leads to death within a week and would not give the hunger striker sufficient opportunity to negotiate his demands.[21] Because of this short period for negotiation, in most cases a thirst strike is not likely to be very effective. The question of the use of force-feeding and/or artificial hydration will be very urgent in these cases, and if intervention is desired, it must be applied within a few days because of the rapid deterioration of the thirst striker's health. Most hunger strikes, however, do not involve a total refusal of food *and* fluids. As in the WMA's definition of a hunger striker, the term hunger strike in this study refers to the refusal of food, but with ingestion of adequate quantities of fluids.

2.5.4. A form of protest

Fourthly and finally, the definition of hunger strike as used in this research requires that the action is undertaken as a form of protest. In the definition of the International Committee of the Red Cross (hereafter: ICRC), a hunger strike must involve actual fasting, which has to be voluntary and has to be pursued for a specific purpose.[22] In 1933, Hogan defined a hunger strike as "any refusal of all necessary food, intending to continue it, in protest against injustice".[23] These last two definitions point to the fact that a hunger strike is pursued for a specific purpose, and lays stress on the motives behind the hunger strike, instead of the process of carrying it out. This in contrast to the definition of the WMA as employed before 2006, which did not require a

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18 Restellini 2007, p. 39.

19 Rieckenbrauck 2009, p. 260.

20 Restellini 2007, p. 39.

21 Crosby, Apovian & Grodin 2007, p. 563. However, in 1992, one case was reported of a prisoner who wanted to use his thirst strike to influence the legal authorities: Neeser, Ruedin & Restellini 1992.

22 Reyes 1998.

23 Hogan 1933, p. 14.

specific purpose to be pursued by the hunger striker. I agree with the view of Reyes of the ICRC and Hogan, that one of the main characteristics of a hunger strike is that it is employed for a particular reason and purpose. This makes a hunger strike different from all other forms of food refusal. As Reyes rightfully notes, the French term for hunger strike, "*jeûne de protestation*" (literally: fasting as a form of protest) is arguably a better general term, as it emphasises the motives and specific purpose of the hunger strike, rather than the process of carrying it out.[24]

3. DIFFERENCE FROM SUICIDE AND EUTHANASIA

Because of the strong determination of some hunger strikers who fast until the end, it is sometimes argued that a hunger strike is a form of suicide or euthanasia. But, there are important differences. In most cases, a hunger strike is not meant as a way to commit suicide. The aim of suicide is death, but death is not the desired outcome for a hunger striker. The hunger striker hopes that his demands will be met and that he can start eating again. Tagawa correctly argues that "suicide has the goal of ending life, while the hunger striker seeks to draw attention to conditions which the striker is protesting".[25] In other words, with hunger strikes risking death is a means to an end. In fact, hunger strikers do not intend to die; they want to live. They want to live with a better quality of life, for instance, through improvements in basic conditions of imprisonment, or access to justice, or by making a political point for the greater good of society as they see it.[26]

Hunger strikes also differ from other potentially suicidal behaviour because this (kind of) death is a very slow one. This route is usually chosen because its very slowness gives others a chance to meet the political or personal demands of the hunger striker.[27] During this period, the hunger striker can call attention to his cause, and he hopes to achieve his goals and end the strike.

There are also important ethical and psychiatric differences between a person who is suicidal and a hunger striker who is willing to die in pursuit of certain goals. As Wynia states, the latter does not exhibit "suicidal ideation".[28] As stated above, for a hunger striker death is a possibility, but not the objective. Hunger strikers are, unless proven otherwise, not suicidal.[29]

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24 Reyes 1998.

25 Tagawa 1983, p. 575.

26 Gregory 2005, p. 913.

27 Annas 1982, p. 21.

28 Wynia 2007.

29 For this reason, in my opinion, persons within Williams' fourth category do not qualify as hunger strikers (although he refers to them as "strikes"). These persons should be dealt with as psychiatric patients, not as hunger strikers.

Euthanasia (a "good death" in Ancient Greek) has to do with patients who are suffering from severe and incurable diseases for whom living humanely is no (longer) an option. For these patients, euthanasia is a way to avoid an undignified life and a slow and painful death. There has been much debate on the topic of euthanasia, both in Western Europe as in the rest of the world. As with suicide, in euthanasia, the hunger striker's right to life is at stake. But, as stated before, although they accept that their action may ultimately result in death, it is not the intention of hunger strikers to die. Hunger strikes therefore clearly differ from suicide and euthanasia.

4. "ON AND OFF" HUNGER STRIKING

Not all hunger strikes are continuous. Hunger strikers may repeatedly abort the strike and then resume it. This is mostly the case with hunger strikers who state a seemingly substantive objective for their strike. This type of "on and off" hunger striking may usually be innocuous, but it may in extreme cases also be lethal. When hunger strikers die, in these cases, they usually do not die from *acute* (as is the case with total fasting), but *chronic* malnutrition, because of the prolonged duration of the hunger strike.[30]

5. THE PHYSICAL CONSEQUENCES OF A HUNGER STRIKE

As stated before, the aim of a hunger strike is not death, although that may be the ultimate result. A hunger strike causes serious damage to the prisoner's or detainee's body, which increases as the hunger strike continues. For a correct understanding of the course of a hunger strike and the question of whether (and at what moment) intervention can take place, insight into the physical consequences of a hunger strike is essential. In its manual for physicians and other health personnel dealing with hunger strikes, the Dutch Johannes Wier Foundation describes the course of a hunger strike and its physical consequences.[31] Physicians need to be aware of the clinical physiology – the hunger strike's physical consequences and symptoms – to be able to give accurate medical counselling and advice to hunger striking prisoners

30 Allen & Reyes 2009, p. 197.

31 The Johannes Wier Foundation is a human rights organisation for doctors, dentists, nurses and paramedics in the Netherlands. The focus of the organisation is on the specific responsibility of all health care workers regarding human rights (see Ch. 5, § 4.4.). The most recent version of the manual for physicians and other health personnel dealing with hunger strikes was published in 2000 (as Van Es, Van Ojen & Raat 2000), which is currently being revised. An English translation was published in 1995 (Johannes Wier Foundation 1995).

and detainees about what to expect.[32] The WMA, in cooperation with the Norwegian Medical Association and the ICRC, has developed a course "Doctors working in prison: human rights and ethical dilemmas". This e-learning course aims to raise doctors' awareness on their role in the various conflicting interests between the patient and the prison administration. In Chapter 5 of this course, guidance is provided to the prison doctor and doctors who work in other places of detention who are confronted by hunger strikers.[33]

In its manual, the Johannes Wier Foundation distinguishes four phases in the hunger striking process, each with its own characteristics and physical changes. The first phase of the hunger strike covers the first week. The second phase covers the first month of the hunger strike. After this first month the so-called sickness phase and the final phase can be distinguished. Other authors in (mostly medical) literature have also investigated the physical consequences of a hunger strike.[34] The following data were compiled from these sources. Together they represent the generally accepted views in the medical world on the course of a hunger strike and its physical consequences. However, it should be noted that these are just general rules. Individual factors and characteristics of the hunger striker, such as his original physical condition, fitness and weight, as well as his age, may influence the physical consequences of the hunger strike.

In general, it can be said that the hunger strike is mostly handled well in the first week. There are only few risks, provided that fluid intake is sufficient. The hunger striker's blood sugar level drops initially, but remains stable at a lower level. Hunger pain and gastric spasms can occur, but disappear in most cases after a few days. Physical exercise is still possible in this first phase of the hunger strike.[35] Most hunger strikes do not last longer than one week. These hunger strikes do not cause a serious risk to the hunger striker's health if sufficient fluids are ingested.

The second phase covers the first month of the hunger strike. After the first week, the hunger striker starts to experience dramatic weight loss.[36] Apart from the weight loss, other physical changes like bradycardia (an abnormally slow heart rate, of less than 60 beats per minute) and orthostatic hypotension (a sudden drop in

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32 This importance is also stressed by Kalk et al. 1993 and Peel 1977.

33 The course is available on the website of the Norwegian Medical Association: <http://nettkurs.legeforeningen.no/course/category.php?id=6> (last accessed on 5 January 2012).

34 For example, Peel 1997, Kalk et al. 1993, Başoğlu et al. 2006, Kenny, Silove & Steel 2004, Faintuch et al. 2001, Altun et al. 2004, WMA 2006, Restellini 2007, and Crosby, Apovian & Grodin 2007.

35 Johannes Wier Foundation 1995, p. 6.

36 This dramatic weight loss in the beginning of the hunger strike is mainly caused by the body's loss of water and salt. The average weight loss during the hunger strike is 10 kilos per month. Independent close medical monitoring and care after a weight loss of 10% in lean healthy individuals is recommended. If the pre-hunger strike weight is unknown, a maximum of 10 days' hunger strike, or a body mass index of less than 16.5 kg/m² should be the trigger. Johannes Wier Foundation 1995, p. 5, Crosby, Apovian & Grodin 2007, p. 564, Peel 1997, p. 829, and Scobie 1998, p. 829.

blood pressure that occurs when a person assumes a standing position) can cause dizziness and sometimes headaches. The hunger striker becomes increasingly weak, accompanied by dizziness, making the upright position difficult to maintain. These physical changes may impede mobility. Fatigue also occurs more quickly, as well as muscular pain even during minor exertion. Because of decreased metabolism, the hunger striker's body temperature will drop. In this first month of the hunger strike, the liver and intestines will furthermore start to atrophy, followed by the heart and kidneys. Muscle, including heart muscle is gradually lost. After three weeks the hunger striker's condition may have deteriorated to the extent that hospitalisation should be considered to enable better and more specialised care.[37]

After the first month, the sickness phase sets in. The turning point nearly always occurs around the 40th day of the hunger strike. The hunger striker starts to feel seriously ill and is often bedridden. This general feeling of sickness can be accompanied with loss of hearing, deteriorating eyesight, haemorrhage, double vision, and nausea. There is no mental deterioration, but concentration problems, apathy and difficulties in formulating speech may occur.

The final phase, which lasts only a few hours, is characterised by mood swings and confusion, followed by coma and death. The stages in this phase all happen very quickly, and death will occur within a few hours. Important decisions concerning medical intervention and treatment must have been made before this moment, because there is no time left to "negotiate" in this final phase of the hunger strike. A team of informed specialists, as well as an ambulance should be ready and standing by.[38] Death as a result of a hunger strike will finally occur, in most cases, as a result of cardiovascular collapse (circulatory failure), dysrhythmias (disordered heart rhythm), or several hours after the induction of a comatose state due to hypoglycaemia.[39]

After a loss of 10% of the body weight (or a BMI <16.5) continuous medical monitoring and care is recommended. Major physical problems arise at a weight loss of about 18%. Starvation is life-threatening when more than 30% of the original body weight is lost.[40] Force-feeding can be urged to preserve the health and life of the hunger striker. Wynia notes in this respect that "[t]here is no medical need to force-feed hunger strikers prior to significant weight loss and cognitive decline".[41]

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37 Johannes Wier Foundation 1995, pp. 5-7, Restellini 2007, p. 39, and Kenny, Silove & Steel 2004, p. 238.

38 Johannes Wier Foundation 1995, p. 7.

39 Restellini 2007, p. 39 and Crosby, Apovian & Grodin 2007, p. 564. In three Turkish cases, studied by Altun et al., of deaths due to hunger strike, the prolonged caloric deficiency finally resulted in multiple organ failure, severe sepsis and ventricular fibrillation, finally causing the death of the hunger strikers (Altun et al. 2004, p. 35).

40 Johannes Wier Foundation 1995, p. 5, Crosby, Apovian & Grodin 2007, p. 564, Pont 2009-II, p. 257, Peel 1997, p. 829, and Scobie 1998, p. 829. Scobie (1998, p. 829) notes that the rate of weight loss is greater in lean than in obese hunger strikers.

41 Wynia 2007.

6. RECOVERY AFTER A HUNGER STRIKE

In many cases the hunger striker stops before the serious injury is done. If the hunger striker survives after termination of a hunger strike, a period of recovery begins. The longer the hunger strike lasted, the longer the convalescence period will take. If the hunger strike lasted longer than three weeks, a convalescence period of about three months is to be expected. Severely undernourished people are usually able to take in food orally rather quickly, sometimes already after a couple of days, but medical assistance remains necessary. Once a hunger strike of more than three weeks is over, re-alimentation is potentially dangerous. After the termination of the hunger strike, the hunger striker should be careful not to ingest too many carbohydrates, especially if no supplement of salt was taken during the hunger strike.[42] The convalescent hunger striker needs to consume small amounts of food which are low in processed sugars and protein.[43] After the hunger strike, the hunger striker should also immediately begin with the intake of additional supplements, such as thiamine and multivitamins.[44] Physicians should be aware of the dangers of the so-called refeeding syndrome, which can have serious effects and even cause death. Ingesting too many carbohydrates after fasting can cause measurable weight gain and potentially acute oedema, which can have fatal consequences. Cardiac problems are also a potential hazard of refeeding. Hospital monitoring needs to be continued for several days after eating has restarted. Hunger strikers are often not aware of the complex psychological processes that are disrupted by their hunger strike or the risks of starting to eat again. Doctors who work with hunger strikers must be aware of the processes and potential problems of the unusual metabolic situation the hunger strike has created. The period of recovery can take longer than the period of the hunger strike. Doctors should therefore not stop guidance when the hunger strike ends. Not only physical care is of importance in this respect; psychosocial guidance often continues to be as necessary as it was during the hunger strike.[45]

7. DEATH AS RESULT OF A HUNGER STRIKE

As stated above, the turning point in a hunger strike nearly always occurs around the 40th day. This is also demonstrated in a short story by Franz Kafka on a 'hunger artist', who is involved in professional fasting.

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42 Johannes Wier Foundation 1995, p. 9.

43 Peel 1977, p. 830. For more information on the refeeding procedure after a hunger strike, see Faintuch et al. 2001.

44 Sebo et al. 2004.

45 Johannes Wier Foundation 1995, p. 9 and Peel 1997, p. 830.

> "The longest period of fasting was fixed by his impresario at forty days, beyond that term he was not allowed to go, not even in great cities, and there was good reason for it, too. Experience had proved that for about forty days the interest of the public could be stimulated by a steadily increasing pressure of advertisement, but after that the town began to lose interest, sympathetic support began notably to fall off."[46]

After 40 days, the hunger striker becomes seriously ill, and bystanders are confronted with the physical decline of the hunger striker.

If no intervention is undertaken, the moment of death is strongly influenced by the hunger striker's decision to take extra liquids and calories, such as tea with sugar and salt, fruit juices, or vitamin supplements to prolong his life. Some hunger strikers even take small amounts of food. Total lack of food is likely to cause death in about 42 to 79 days, if only water is consumed. Turkish prisoners in 2000 survived for a remarkably long period, some of them dying after a period of 170 days. This can (probably) be explained by the extra doses of thiamine,[47] vitamin compounds, and other liquids these prisoners were taking. This was done because the ingested vitamins decrease the chance of permanent nutritional disability (neuropathy or congestive heart failure) if the strike should end. Because of the prolonged period of hunger strike, the duration of negotiation with regard to the aims and goals of the hunger strike was also extended.[48] After stopping the intake of these extra vitamin compounds and liquids, the Turkish prisoners died after 67 to 86 days.[49] In general, it can be concluded that, without the intake of extra vitamin compounds and liquids, most hunger strikes become life-threatening from the 40th day on and pose a serious risk to the hunger striker's life. Although certain medical factors (such as heart disease) can predispose a rapidly fatal evolution of a hunger strike, in practice determining medically the risk and timing is difficult because of many different factors, such as the type of fasting, detention conditions (temperature, humidity) and mental stresses involved.[50]

Deaths as a result of a hunger strike are not uncommon in (recent) history. The problem has been particularly severe in Northern Ireland. Hunger striking as a means of obtaining social or economic redress, or as a method of political confrontation has a long history in Ireland, which has led to numerous deaths as a result of these hunger strikes. In October 1923, more than 8000 political prisoners, opposed to

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46 Kafka 1971, p. 270.

47 The intake of thiamine, a vitamin used by the body to break down sugars, is very important for the prevention of Wernicke's encephalopathy, a severe brain disorder caused by thiamine deficiency, that can cause loss of specific brain functions and irreversible neurological damage if the hunger striker survives.

48 Oguz & Miles 2005, p. 2.

49 Altun et al. 2004, p. 37.

50 Restellini 2007, p. 40.

the 1921 Anglo-Irish Treaty, went on a hunger strike. Two of them died before the protest was called to a halt. One of the most remarkable hunger strikes in Irish history was that of ten IRA prisoners in the HM Maze Prison near Belfast in 1980 and 1981, demanding political status for all Irish republican political prisoners.[51] This collective hunger strike generated a lot of media attention and political turmoil. In May 1981, Bobby Sands was the first to die as a result of his hunger strike after 66 days, followed later by the nine other hunger strikers. The story of the life of IRA prisoner Bobby Sands, who became a martyr as a result of this hunger strike, was turned into a cinematographic tour de force in 2008, called *Hunger*.[52]

Not only in Ireland, but also in Turkey throughout decades prisoners have died as a result of hunger strike. In Turkey, several prisoners – four in 1982, six in 1984, and 12 in 1996 – were reported to have died from hunger strike. The longest nationwide hunger strike was initiated by political prisoners and outside supporters in October 2000 to protest against the introduction of the F-type prison system, consisting of isolation of political prisoners. This hunger strike is not only one of the longest (as mentioned earlier), but also one of the biggest (in the three years since the hunger strike began more than 2000 people have been on strike at various times and for various intervals) and deadliest in recent history. By the middle of 2003, 107 hunger strikers were reported to have died as a result of their actions.[53] Many others of them suffered permanent brain damage as a result of their hunger strike.

Also outside Northern Ireland and Turkey deaths as a result of a hunger strike have occurred. On 23 February 2010, Orlando Zapato Tamayo, a Cuban human rights activist, died after a hunger strike of 85 days.[54] On 24 July 2011, Tohuami Hamdaoui had the dubious honour of being the first prisoner to die in a Spanish prison after a hunger strike of five months, despite being force-fed.[55]

Although deaths as a result of a hunger strike are not uncommon in history, they do not occur regularly, when compared to the numerous hunger strikes that occur annually worldwide. It is difficult to know to what extent the relatively low level of fatality is due to the limited goals or commitment of hunger strikers or to the forcible intervention by medical or staff of the prison or other place of detention. The decision for a hunger striker to start eating again before serious injury is done can, as the British Medical Association (hereafter: BMA) correctly notes in this respect, also be motivated by

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51 Sweeney 1993. See also Ch. 6, § 4.5.

52 Directed by Steve McQueen. This movie, which provides a probing and impressive report on Bobby Sands' hunger strike, was well received by critics and the public and won several important awards, such as a Camera D'Or at the Cannes Film Festival 2008.

53 Altun et al. 2004, p. 35, and Anderson 2004, p. 817.

54 <http://news.bbc.co.uk/2/hi/americas/8533350.stm> (last accessed on 5 January 2012).

55 < http://www.euroweeklynews.com/news/costa-blanca/costa-blanca-north/88307-inmate-dies-after-hunger-strike> (last accessed on 5 January 2012).

> "an intended limitation of the fast, change of mind of the prisoner, persuasion by family, lawyer or prison officers, or capitulation in the face of pressure, including force-feeding, from the authorities. In certain circumstances the death of one or more hunger strikers may have been anticipated in advance and may even have represented an element in a confrontation with a government, though this appears to be very rare."[56]

8. PROCEDURES FOR FORCE-FEEDING AND ARTIFICIAL FEEDING

In § 2.4 of this chapter, I elaborated on the definitions of force-feeding and artificial feeding. Below, I will go into the different procedures of force-feeding and artificial feeding, the use of force and its medical risks.

As Picture 1 shows, there are several ways in which feeding can be administered to a patient. Different methods can be used to force-feed a hunger striker. Each of these has its own advantages and disadvantages that make it a less or more suited way of feeding a prisoner or detainee whilst on hunger strike. In the following I will go into these different ways of feeding, the specific ways of application, the possibilities and risks. In administering nutrition to patients, two 'routes' can be distinguished: the enteral route and the parenteral route. Picture 1 shows both routes of administration.

8.1. ENTERAL FEEDING

Enteral feeding is also called tube feeding, as enteral feeding always implies the application of a feeding tube into the patient's body. Food can be applied via the enteral route through a tube that is placed in the body. This tube can be applied in the nose (a nasogastric or nasoenteral tube), the stomach (a gastric feeding tube) or the small intestine (a jejunostomy or percutaneous endoscopic jejunostomy tube). Food administered in these ways passes directly into the hunger striker's body.

Enteral tube feeding is the preferred method of nutritional support when the patient is unable or unwilling to consume an adequate oral diet, which is the case in a hunger strike.[57] The nasogastric feeding tube is most commonly used to force-feed prisoners and detainees on hunger strike. A nasogastric feeding tube is inserted into the nose, through the oesophagus, into the stomach. Sometimes, the tube is not inserted through the nose, but through the mouth of the hunger striker. To facilitate insertion, the tube can be lubricated with warm water or a different lubricant. The

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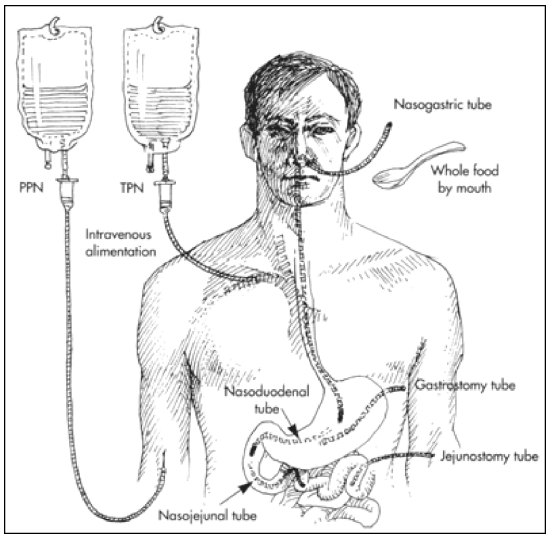
[56] BMA 1992, p. 121.

[57] <http://www.rxkinetics.com/tpntutorial/2_3.html> (last accessed on 5 January 2012).

Picture 1: Routes of administration of nutrients[58]



prisoner or detainee who is being force-fed is often given an anaesthetic and pain killers. However, he still experiences severe nausea and vomiting. The process of force-feeding can be both painful and dangerous. It can also be problematic given the frequency with which it must occur.[59] The physician who applies the force-feeding should be careful not to administer too many nutrients in a too short period of time, which can cause the hunger striker to lose consciousness, and even die as a result of the treatment.

The application of the tube has serious medical risks, especially if the hunger striker resists. These medical risks include permanent handicaps, damage to vital organs, and even death if the tube is wrongly inserted and the food enters the lungs. Deaths from the application of force-feeding are not uncommon throughout history. In the early 20th century the suffragettes, a militant movement for women's suffrage, frequently went on hunger strike while being detained in British prisons. Several of these suffragettes died as a result of force-feeding. Because of the risk of misplacement, the tube should only be inserted by trained medical staff, not only to minimise the risk of misplacement of the tube, but also because of the fact that only trained medical staff will be sufficiently experienced to recognise whether the feeding tube is inserted properly. Repeated insertions of the feeding

[58] Image by RxKinethics. See <http://www.rxkinetics.com/tpntutorial/1_4.html> (last accessed on 5 January 2012).

[59] Silver 2005, p. 637.

tube may cause damage to the prisoner's or detainee's nasal cavity, pharynx or oesophagus. Because of this risk, combined with the risk of tube misplacement and the occasional need to check the position of the tube by X-ray, nasogastric feeding (as well as nasoduodenal and nasojejunal feeding) is not an ideal long-term method of tube feeding.[60]

A gastronomy or jejunostomy can be used as an alternative to repetitive feeding tube insertion for long-term feeding, as this, *inter alia,* causes less discomfort to the patient. A gastric feeding tube is a tube that is placed into the stomach through an incision in the abdominal wall; a jejunostomy is directly inserted in the small intestine. The difference between these and other methods of enteral feeding is that the placement of a gastronomy or jejunostomy requires a surgical intervention. Risks include, *inter alia*, surgical complication, device dislodgement, wound infection and bowel perforation.[61]

8.2. PARENTERAL FEEDING

As opposed to enteral feeding, which is directly administered into the stomach, in parenteral feeding, the nutrition is applied through the patient's veins; intravenously. The principal forms of parenteral feeding are Total Parenteral Nutrition (hereafter: TPN) and Peripheral Parenteral Nutrition (hereafter: PPN).

Parenteral feeding is called TPN if no other nutrition is provided. TPN is administered through a catheter that is placed in a major blood vessel that lies close to, and leads to the heart; mostly it is inserted into the subclavia (in the chest, as shown in Picture 1) or in the jugular vein (in the neck). In this way the normal process of eating and digestion is by-passed. In medicine it is agreed that enteral nutrition is preferred over parenteral nutrition. Enteral nutrition is safer, more cost effective, and has physiologic (for example, nutrients are metabolised and utilised more effectively) and immunologic benefits over parenteral nutrition.[62] TPN, nonetheless, is given to patients who cannot (or can no longer) get nutrients from food by the oral or enteral route. It is used in patients who are, because of health problems such as oesophageal cancer or swallowing difficulties, not (or no longer) able to take in food by mouth and to absorb enough nutrients through the stomach. It can also be applied to feed people who are in a coma, or to patients who are severely malnourished because of the eating disorder anorexia nervosa. The primary goal of TPN is to provide patients with adequate calories and protein to prevent malnutrition and its associated complications. It contains the same elements as 'normal' feeding; it is a mix of protein, carbohydrates and fat for

60 Pearce & Duncan 2002, pp. 199-200, and Crosby, Apovian & Grodin 2007, p. 565.

61 Crosby, Apovian & Grodin 2007, p. 565.

62 <http://www.rxkinetics.com/tpntutorial/1_4.html> (last accessed on 5 January 2012).

energy and tissue development. Additionally, extra dietary components such as water, electrolytes, vitamins and trace minerals can be administered.[63] TPN can be used as a method to force-feed hunger strikers. TPN may be used when feeding is desired for a longer period. It has several drawbacks however. Complications are related to both obtaining and maintaining a route of central vascular access. Unless the prisoner or detainee is sedated or is too weak to resist, in most cases, he will attempt to obstruct treatment by pulling out the needle(s) used to feed him. If TPN is desired for a longer period, the prisoner or detainee should permanently be strapped down to prevent him from removing the needles. If the hunger striker obstructs the insertion of the needle, this obstruction could lead to a severe loss of blood that could be fatal in just three to four minutes. This rather intrusive procedure furthermore also carries a risk of infection, especially if the hunger striker refuses to cooperate.[64] Besides infection, venous thrombosis is a major problem that can occur after central venous access is established.[65]

Besides TPN, the other principle form of parenteral feeding is PPN. PPN contains similar nutrient components as TPN, but in a lower concentration. Because of this lower concentration it can be delivered by peripheral veins, which are not in the chest or abdomen, but are in the legs, arms and hands. These veins are the most commonly used intravenous access route. These are smaller veins, so large fluid volumes must be administered to provide comparable nutrients. PPN is used for shorter periods (up to two weeks) because of the limited tolerance of these smaller veins.[66] Because of the smallness of the veins and its limited tolerance, PPN cannot be used to provide a complete feeding, as in TPN. A peripheral intravenous line is mostly suited for the administration of fluids, medicine and vitamins.

Both forms of parenteral feeding, TPN and PPN, are often used after the termination of a hunger strike, or when the hunger strike loses consciousness. Physicians should then be aware of the refeeding syndrome mentioned earlier.

8.3. THE USE OF FORCE AND MEDICAL RISKS

If a hunger striker is fed against his will, he is likely to resist treatment. Whether or not force is to be used depends on the prisoner's or detainee's mental condition. If he has already lapsed into a coma, no resistance can be expected. If the hunger striker is conscious, in each of the above-mentioned ways of force-feeding, he has to be physically restrained or anaesthetised to prevent him from resisting insertion of the tube or the catheter. In the case of feeding through a nasogastric or gastric

63 <http://www.rxkinetics.com/tpntutorial/3_1.html> (last accessed on 5 January 2012).

64 Silver 2005, pp. 637-638.

65 <http://www.rxkinetics.com/tpntutorial/3_3.html> (last accessed on 5 January 2012).

66 <http://www.rxkinetics.com/tpntutorial/1_4.html> (last accessed on 5 January 2012).

feeding tube or in the case of intravenous feeding, the prisoner or detainee is not only to be restrained when the tube or catheter is inserted, but also afterwards to prevent the removal of the tube or catheter. Resistance by the hunger striker can be very powerful, as he will not have consented to his treatment and (even though severely weakened by the hunger strike) can be very determined not to be force-fed.

The force necessary to restrain the hunger striker, the procedure of the force-feeding, and the accompanying medical risks can be described as very invasive regarding the prisoner's and detainee's right to self-determination and his right to physical integrity. With force-feeding there are not only significant clinical risks, but it may also cause psychological trauma to the person involved. With regard to the force that is used and the invasiveness of the medical procedures applied, it is not surprising that hunger strikers have argued before the EComHR and the ECtHR that force-feeding constitutes torture, inhuman or degrading treatment.[67]

In February 1974, in an open letter to the BMA, the Action Committee Supporting Irish Prisoners described the techniques then used in Britain: "They are forcibly fed in the following manner. Their mouths are forced open with a surgical instrument and a thick greased orange tube is pushed down their throats. A liquid mixture is then poured down and this is almost always followed by vomiting and nausea. The prisoners are held down by wardens." Doctors writing to the BMA in 1974 added other details: "The method used for forcible feeding has remained the same since the beginning of this century when suffragettes were fed in this way. Between the teeth a wooden block is placed, containing a hold through which a greased stomach tube is passed. This process is performed once or twice a day and may be repeated if vomiting occurs. Where resistance is encountered, a steel clamp is used to prise open the mouth, and several people may be required to hold the subject still."[68] Similar accounts of the methods of force-feeding were given on force-feeding practices in Germany during the hunger strikes by members of the Red Army Faction in the 1970s, as described by several authors. In these cases, the prisoner was taken on a stretcher to the medical unit, strapped or held down by four, five or more guards (when necessary, a guard sits on his knees and a guard grips his head), after which a mouth-piece with a hole in it was place in his mouth, a greased tube was then put down in the stomach, and the food was forced down the tube. In some cases, force-feeding was applied approximately five times a day, each process taking about 20/30 minutes.[69] After being force-fed, many of the hunger strikers vomited, both as a normal side-effect of the force-feeding, but also to underline their resistance to

67 See Ch. 5, § 3.4.

68 BMA 1992, p. 120.

69 Passmore 2009, p. 35, 'Wir oder sie auf Leben und Tod' (Us or them, a life and death fight), *Der Spiegel,* Vol. 36, d.d. 29 August 1977, p. 30 and Winiger 1978, pp. 390-391.

the practice. To avoid this, the hunger strikers were often left strapped to the table for an hour after the procedure to allow for some digestion.[70]

Although medical science has developed rapidly throughout recent decades, the application of force-feeding has remained intact since the beginning of last century. Gregory, in this respect, notes:

> "Let us be under no illusion as to what force-feeding means. Anyone who has tried to pass a nasogastric tube or insert an intravenous infusion into an uncooperative and confused postoperative patient knows how grim that can be. Force-feeding against someone's will must entail force, restraint, or sedation. It does not conjure up a pretty picture."[71]

Finally, it must be mentioned that force-feeding will not always prevent the death of the hunger striker.[72] The question of force-feeding usually becomes an issue around the 40th day of the hunger strike. If the prisoner or detainee has already lapsed into a coma (and the dying process has already started), force-feeding is likely to be too late and will not result in preventing the prisoner's or detainee's death. If the hunger striker is nevertheless force-fed and survives, this will probably be with significant permanent physical damage because of long-term malnutrition. To increase the chances of survival, force-feeding should start before this time.

9. CONCLUSIONS

People can have different motives to refuse to take nutrition and/or fluids, but not all sorts of food refusal can qualify as a hunger strike. Persons who are deprived of their liberty form a specific group of hunger strikers, as the custodial setting involves a strong coercive element; the dilemma between the responsibility of the State and the caretakers involved for the health of the hunger striker on the one hand, and the individual rights of the hunger striker on the other is here most intense. A hunger strike can be defined as a determined effort by a mentally competent person who has indicated that he refuses food as a form of protest. Accordingly, a hunger strike must involve an element of protest, the hunger striker must be competent, he must refuse food, and the hunger strike must be pursued as a determined effort. In this chapter I have elaborated on these different elements of the definition, as well as on

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70 Passmore 2009, p. 35.

71 Gregory 2005, p. 913.

72 Cases are known in which the prisoner was force-fed, but still died as a result of his hunger strike. This was the case with, for example, IRA terrorist Michael Gaughan and Red Army Faction terrorist Holger Meins in 1974, several Turkish prisoners in 2000 (Van Es 2003), and Tohuami Hamdaoui in 2011 <http://www.euroweeklynews.com/news/costa-blanca/costa-blanca-north/88307-inmate-dies-after-hunger-strike> (last accessed on 5 January 2012).

the other definitions that are used in this research. A prolonged hunger strike has serious physical damage and can ultimately cause death of the prisoner or detainee involved. Force-feeding can be used to intervene in a hunger strike. Force-feeding can be applied through enteral feeding or parenteral feeding. Both methods entail force to restrain the hunger striker and are accompanied by medical risks, especially when the hunger striker resists his treatment.

CHAPTER TWO

THE CONCEPT OF PERSONAL AUTONOMY, THE RIGHT TO SELF-DETERMINATION AND INFORMED CONSENT AND REFUSAL IN HEALTH CARE

1. INTRODUCTION

As demonstrated in Ch. 1, § 5, a hunger strike has serious physical consequences and can even cause the hunger striker to die. Parties involved, such as the government, custodial officials and physicians, will often feel the urge to preserve life and intervene in the hunger strike through the use of force-feeding. The question arises as to whether the serious consequences of the hunger strike can justify an intervention against the express wishes of the person involved. Before exploring this question in depth in the next chapters, in this chapter I will explore the meaning and scope of the underlying concepts in this discussion: the concept of personal autonomy, the right to self-determination and informed consent in health care. Almost all hunger strikers are determined not to be force-fed and will refuse medical treatment. In this way, the physician and the State are confronted with the patient's autonomy and his right to self-determination. Force-feeding hunger strikers also raises delicate questions with regard to consent.

For a correct understanding of the terms used, I will first explore the definitions of personal autonomy and the right to self-determination, and secondly, their relation to the concept of the right to physical integrity and informed consent. Thirdly, I will elaborate on informed consent and refusal, its constituting elements and exceptions. Fourthly, attention will be paid to paternalism as an argument to overrule issues of patient autonomy. Fifthly, I will elaborate on the element of competence as a precondition for informed consent and its role in hunger strikes. Sixthly, I will go into the issue of surrogate decision-making for incompetent patients. Seventhly, I will explore the codifications of personal autonomy, the right to self-determination and informed consent. Eighthly and finally, I will offer conclusions.

2. DEFINITIONS OF PERSONAL AUTONOMY AND THE RIGHT TO SELF-DETERMINATION

As noted above, for a correct understanding of the terms in the following parts of this research, I will go into the definitions of the concepts of personal autonomy, the right to self-determination and informed consent in health care.

Currently, respect for personal autonomy is a fundamental principle in modern medical ethics. It is considered to be one of the four leading principles in medical ethics, alongside beneficence (promoting benefit), non-maleficence (avoiding or minimising harm), and justice (also referred to as fairness). Apart from the right to health care, respect for personal autonomy can be said to be one of the most fundamental principles underlying health care law.[1] Personal autonomy is often referred to as *patient autonomy* in the literature. As I believe that patients – just like people who are not sick – as a basic principle are entitled to respect their personal autonomy, the two terms will be considered synonymous for the purposes of this study. But what is personal autonomy? Conceptually, autonomy has always been an important concept in philosophy and ethics. It is linked to basic notions and ideas on liberty, freedom, independence and privacy. Many philosophers and ethicists have shed light on it, and its nature and value have generated much debate. Different dimensions of personal autonomy and problems and dilemmas in relation to personal autonomy are discussed in medical ethics. In the medical-ethical discussions, many elements of the broader philosophical discussions can be recognised. As Schermer notes, this is not surprising since the leading contemporary theories about autonomy in legal and political philosophy developed simultaneously with contemporary medical ethics.[2]

Historically, the concept of autonomy is defined by the etymology of the terms *autos* (self) and *nomos* (rule or law). This concept was first applied to the Greek city State. A city had *autonomia* when its citizens made their own laws instead of having laws imposed upon them by some conquering power. This idea gradually came to be applied to persons when their decisions and actions were their own, i.e. when they became self-determining. This evolution was stimulated when questions of following one's conscience were raised by religious thinkers such as Aquinas, Luther and Calvin, who placed great stress on the individual acting in accordance with reason as shaped and perceived by the person. This idea was taken up by the Renaissance humanists.[3] Respect for personal autonomy is as deeply rooted in common morality as any principle, but its nature, scope and strength have been fiercely debated.

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1 Den Exter 2002, p. 66.

2 Although they influence each other, authors in the respective fields often use different definitions and interpretations of the major concepts. Schermer 2001, p. 23.

3 Dworkin 1988, pp. 12-13.

The historical development of the concept of autonomy has not led to one unambiguous definition. As Dworkin notes, "we have one concept and many conceptions of autonomy".[4] Several authors argue for a specific definition of the concept of autonomy, based on their scope, specific viewpoint, or continental tradition. For instance, the term autonomy acquired a different meaning in America than it did in Europe. In American ethics, autonomy is defined as an "empirical" concept, as the capacity to act intentionally, with understanding and without controlling influences. European ethicists, by contrast, often interpret the principle of autonomy as a "transcendental" term in the Kantian sense, as the capacity of human reason to impose absolute moral laws upon itself is based on the idea that rational human wills are autonomous.[5] Beauchamp and Childress note that although no generally internationally accepted definition exists, virtually all authors on autonomy agree that two conditions are essential for autonomy: liberty (independence from controlling influences) and agency (capacity for intentional action). Nevertheless, there is no agreement on the meaning of these two conditions or on whether there are other essential conditions.[6]

For the purpose of this study, I will use the definition of personal autonomy of Beauchamp and Childress, who have stated that autonomy reflects the fundamental norm that each individual is entitled to determine his own course of life in accordance with a plan chosen by himself.[7] They furthermore believe that

> "personal autonomy encompasses, at a minimum, self-rule that is free from both controlling interference by others and from certain limitations such as an inadequate understanding that prevent meaningful choice. The autonomous individual acts freely in accordance with a self-chosen plan, analogous to the way an independent government manages its territories and establishes its policies."[8]

In this elaboration of personal autonomy, two aspects are mentioned that relate to the two concepts of freedom as introduced by Isaiah Berlin (1909-1997). In his 1958 lecture *Two Concepts of Liberty*,[9] Berlin describes two notions of freedom:[10]

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4 Dworkin 1988, p. 9.

5 Leino-Kilpi et al. 2000, p. 55. Kant has been very important in the debate on the concept of personal autonomy. Some authors, e.g. Schneewind 1998, even argue that he is the originator of the concept.

6 Beauchamp & Childress 2009, p. 100, with extensive references to literature under footnote 2.

7 Beauchamp & Childress 1983, p. 59 as cited by Hendriks 2007, p. 71.

8 Beauchamp & Childress 2009, p. 99.

9 This inaugural lecture was delivered at the University of Oxford on 13 October 1958, and was published as one of his *Four Essays on Liberty*: Berlin 1969.

10 Liberty and freedom can be described as different concepts with different connotations, but in ethical theory, they are closely related. In contemporary writings, they are sometimes used interchangeably and sometimes as different concepts, the exact meaning of which can vary considerably depending on the author. Dworkin, for example, claims that liberty and autonomy are two distinct notions,

negative and positive freedom. The notion of negative freedom is described by Berlin as a "freedom from": the absence of barriers or obstacles to constraints on or interferences with a person's freedom, imposed by other people. The notion of positive freedom is described as "a freedom to": the ability to take control of one's life, pursue and achieve willed goals and realise one's fundamental purposes.[11]

In health care, both negative and positive aspects of the principle of personal autonomy are involved. The negative aspect of personal autonomy requires that restrictive measures do not go beyond the level of intrusion as indicated by the necessary medical care. It also requires that the invasive and dominant character of medicine be limited to a minimum. The positive aspect of personal autonomy requires the promotion of the patient's personal autonomy, through, for instance, disclosure of information and the promotion of autonomous decision-making.

Where the question of applying forced medical treatment arises, the patient's negative freedom, the freedom to be free from oppression or interference by others, is at stake. Yet, in my opinion, with forced medical treatment in general and force-feeding of hunger strikers in particular, the patient's positive freedom is also at stake. The notion of positive freedom focuses on a person's own capacity to make his own choices and direct his life according to his own beliefs. The patient may, after all, choose to refuse medical treatment to change his life in a certain way. This is obviously the case with hunger strikes, which are specifically meant to achieve certain goals that are of special importance to the hunger striker. Accordingly, with force-feeding prisoners and detainees on hunger strike arguments and considerations that relate to both the positive and negative notion of freedom can be involved. In philosophical theories on autonomy, the emphasis is mostly on internal, i.e. positive freedom. With regard to the scope of this study and the research question that focuses on force-feeding, however, the negative notion of freedom will be the most important.

As mentioned earlier, the principle of autonomy is currently one of the fundamental principles in medical ethics. Personal autonomy and respect for physical and physiological integrity in health care received growing recognition after the terrible events that took place during the Second World War. During the Nuremberg trials, the genocide, and the numerous horrific medical experiments performed by medical staff in concentration camps were shown to the world. It was determined that these events were never to happen again and that human rights, including individual autonomy, needed adequate legal protection. Simultaneously,

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although "related in both contingent and noncontingent ways". To clarify the different meanings of liberty and autonomy, Dworkin refers to John Locke's example of a prisoner who is put into a cell and is told that the doors cannot be opened. In my view, liberty and freedom are interdependent and so closely related that I will use these terms interchangeably when referring to positive and negative aspects of these concepts.

11 <http://plato.stanford.edu/entries/liberty-positive-negative/> and <http://plato.stanford.edu/entries/berlin/> (both last accessed on 10 January 2012).

international treaties and conventions were drafted to create a constitutional or other legal basis for personal autonomy, both national and international.[12] The 1948 Universal Declaration of Human Rights has been very important, as it recognises in its Preamble "the inherent dignity and […] the equal and inalienable rights of all members of the human family". To this day, this formula has proven to be an important stimulus in the development of patient rights, such as the right to information and the right to consent to or to refuse treatment. Nowadays, many worldwide multilateral declarations and agreements contain these fundamental patient rights, *inter alia*, the 1950 ECHR and the 1966 International Covenant on Civil and Political Rights (hereafter: ICCPR).[13] Major international organisations, such as the World Health Organisation (hereafter: WHO), the WMA, the Council of Europe and the European Union, have stimulated the development, promotion and implementation of patients' rights in Europe. It is beyond the scope of this study to deal with all the declarations and agreements that contain patients' rights. Those documents that are of relevance to the research topic will be dealt with in Chapter 5.

It can be concluded that personal autonomy is a fundamental principle in current medical ethics that has been increasingly codified in, *inter alia*, documents on patient's rights. Autonomy can act as a warrant for individuals to make their own decisions and as a deterrent for others, notably the State and its agents, to interfere with the individual's self-chosen plan.[14] In this way, it mostly acts as a right to non-interference. Yet, this does not mean that this principle of autonomy has priority over all other principles. Autonomy is not unlimited and has to be balanced against other moral principles, rights and obligations.

An important restriction to the principle of autonomy was introduced by the English philosopher John Stuart Mill (1806-1873). Mill was a liberalist thinker who strongly influenced contemporary ideas of autonomy. His plea for individual freedom in "On Liberty" is very much in line with what is currently considered to be the main argument for autonomy. It has been noted in this respect that, from Kant to Mill, there was a shift from moral autonomy to personal autonomy: the concept evolved from a term which originally meant to express the possibility of ethical principles which were independent from contingent goals, to a notion which denoted the capacity of human beings to live their lives according to their own ideas about what is good.[15] From his utilitarian perspective, Mill argued that the State, the government, society, or other people may not infringe upon individual

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12 Den Exter 2002, p. 69. The expression of personal autonomy, for example as codified in stipulations or expressed in case law on consent to medical treatment, in the legislation of the Netherlands, England and Wales, and Germany will be discussed in Chapter 5.

13 Adopted and opened for signature, ratification, and accession by General Assembly Resolution 2200A (XXI) of 16 December 1966. Entry into force 23 March 1976.

14 Hendriks 2007, p. 71.

15 Nys, Denier, VandeVelde 2007, pp. 6-7, in reference to Waldron 2005.

liberty, except in cases when individual behaviour would cause harm to another; he referred to this as the harm principle.[16] In a famous passage from his introductory Chapter, he states:

> "The object of this Essay is to assert one very simple principle, as entitled to govern absolutely the dealings of society with the individual in the way of compulsion and control, whether the means used be physical force in the form of legal penalties, or the moral coercion of public opinion. That principle is, that the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant."

Mill furthermore concludes that

> "[h]e cannot be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinion of others, to do so would be wise, or even right. These are good reasons for remonstrating with him, or persuading, or entreating him, but not for compelling him, or visiting him with any evil, in case he do otherwise. To justify that, the conduct from which it is desired to deter him must be calculated to produce evil to some one else. The only part of the conduct of any one, for which he is amenable to society, is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute."[17]

Liberty is a key concept in Mill's work. According to Mill, people are free to enjoy their own individual liberty as long as their behaviour does not harm others. This limiting factor is taken into account to ensure that other persons will also be able to enjoy their own individual liberty and sovereignty without interference by others. Preventing harm to others is the sole condition that allows or justifies intervention by the State. The individual's liberty and independence is considered to be a fundamental principle that has to be respected. As Mill states: "Over himself, over his own body and mind, the individual is sovereign".[18]

Applying Mill's harm principle to health care situations implies that, as long as choices made by a competent patient do not harm anybody else, they should be respected. This is different when a patient's behaviour may create a risk to others or the community as a whole (for example public health), such as in the context of

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[16] This harm principle is clearly expounded by Mill. However, it is also discussed in "Second Treatise of Government" by John Locke and considered a leading principle in the work of Joel Feinberg.

[17] Mill 1863, pp. 22-23.

[18] Mill 1863, p. 23.

tuberculosis or other potentially contagious diseases, in which case restrictions on the patient's autonomy may be applied. In all other cases, the patient's independence is absolute. That a person may bring harm to himself or that other persons do not approve of the action are insufficient grounds for intervention. Even when others think that an action is wrong or not in a person's best interests, no intervention can be justified. For that reason, in Mill's view, forced medical treatment with the aim of preventing harm to the patient himself is not acceptable. However, it should be noted that few decisions in health care, no matter how personal, have no impact on others (health professionals, family, friends, or society as a whole). Currently, it is acknowledged that autonomy must be respected, but insofar as such respect is compatible with equal respect for the autonomy of all those potentially affected, and the norms and values of democratic society, including the need to protect human rights.[19] Therefore, a patient's refusal of treatment may not be as absolute as advocated by Mill, as other people's or society's interests may also play a role in the decision to apply forced medical treatment.

To a large extent, Mill's theory can be applied to the situation of prisoners and detainees on hunger strike. As will be demonstrated in Chapter 7, as a basic principle, hunger strikers are sovereign in deciding on medical intervention concerning their body: a hunger striker does not have to tolerate intervention against his will. Still, this sovereignty over his own body is not absolute. I will elaborate on the exception to the basic rule that no intervention is allowed in competent prisoners and detainees on hunger strike in the last chapter of this study.

Within the context of health care, personal autonomy is usually understood as the right to self-determination. When dealing with personal autonomy in health care, in the literature and case law, the terms personal autonomy and right to self-determination are often used interchangeably.[20] In this study, however, this is not the case. In my opinion, personal autonomy is a broad term (referred to as a notion, idea or concept in this research) that, *inter alia*, includes the right to self-determination. In this respect, the idea of personal autonomy as adopted in this research – as reflecting the fundamental norm that each individual is entitled to determine his own course of life in accordance with a plan chosen by himself – resembles the concept of personal autonomy as held by the ECtHR, that has stated that personal autonomy encompasses a multiplicity of rights that are of central importance to the individual's identity. One of these rights is the right to self-determination.[21] For this reason, in this study I will refer to personal autonomy as a principle, notion, idea

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19 BMA 2004, p. 7 and Hendriks 2007, p. 71.

20 Den Exter, for example, considers autonomy and self-determination to be interchangeable notions. Den Exter 2002, p. 69. For this reason, the notion of personal autonomy is sometimes also referred to as a *right to* personal autonomy. The ECtHR has also accepted such right to personal autonomy, see § 8.1 of this chapter.

21 See § 8.1 of this chapter.

or concept. The terminology of the term right to self-determination specifically emphasises its key element, which is that a person has the right to decide for himself in general, and in issues concerning his health and body in particular. Where the question of forced medical intervention exists, the right to self-determination of the person involved, as a part of the broader notion of personal autonomy, is at stake.

The right to self-determination, as used in my study, does not refer to the right to self-determination of *peoples*, as is often used in international law. Self-determination in international law embodies the right for all peoples to determine their own economic, social and cultural development, and refers to the collective self-determination of nations. It is codified, *inter alia*, in Article 1 of both the ICCPR and the International Covenant on Economic, Social and Cultural Rights (hereafter: ICESCR). Both state that "[a]ll peoples have the right of self-determination". In the context of this study, however, the right to self-determination refers to the right to self-determination of the *individual*.

The right to self-determination plays an important role in issues concerning (forced) medical treatment, organ donation, the use of body tissues (for example, for medical research), and delicate matters concerning life and death, such as abortion, and euthanasia. An important consequence of the idea of respect for personal autonomy and the right to self-determination in health care is the fact that the patient's consent is required before medical treatment can be performed. I will now elaborate on the relationship between the concepts of personal autonomy, the right to self-determination, the right to physical integrity and informed consent and refusal.

3. THE RELATIONSHIP BETWEEN THE CONCEPTS OF PERSONAL AUTONOMY, THE RIGHT TO SELF-DETERMINATION, THE RIGHT TO PHYSICAL INTEGRITY AND INFORMED CONSENT AND REFUSAL

In the literature, there has been much debate on the relationship between the concept of personal autonomy and the right to self-determination on the one hand, and informed consent on the other. In medical ethics, informed consent is usually considered to be an important *means* of achieving the goal of patient autonomy. According to others, the very attempt to secure consent can be considered an *expression* of respect for the autonomy of the patient.[22] I agree with this latter vision, that the concept of informed consent is an expression of respect for patient autonomy. In my opinion, personal autonomy is the foundation of the concept of informed consent. With forced medical treatment, the right to physical integrity is

[22] Schermer 2001, pp. 24-25, with references.

under threat. The right to physical integrity serves as a defensive right, and is under threat from forced medical intervention.

It is not so much the issue of informed consent that is of importance in issues of forced medical treatment in general and force-feeding in particular – it is the issue of informed refusal. The issue of force-feeding hunger strikers raises particularly contentious questions when informed refusal to treatment by the person involved exists. As informed consent implies a right to refuse and because of the fact that medical-ethical reflections on the issue of forced medical treatment have mostly been discussed in terms of informed consent, I will elaborate on this concept and its consequences for the issue of forced medical treatment in the next section.

4. INFORMED CONSENT

Consent, in terms of voluntary choice, has always been central in contract law. Contract law, both in principle and in practice, allows parties to enter into arrangements on terms of their own choice, each party imposing obligations on itself in return for obligations another party has placed upon itself. This "freedom of contract" differs from duties under criminal law and tort law, which bind all parties regardless of consent.[23] In this way, consent can be seen as the justificatory basis of contract. In health care situations, a patient enters into a contract/agreement with the physician to provide care. This is a special kind of contract because of the (possible) invasive nature of medical care and the dependence of the patient on the medical professional. The relationship between patient and physician is also characterised by a relationship that is based on trust. Accordingly, patients trust physicians to act in their best interest to protect and to preserve their health. Consent is central to contract law and, with regard to these elements, is even more important in medical situations. The decision whether or not to consent to treatment by the patient is not a medical decision, but a personal decision that can only be made by the patient directly affected or by his representative.[24]

Decisions about medical treatment are ideally made through discussion, with the physician's clinical expertise and the patient's individual needs and preferences being shared in order to select the best treatment option. In this patient-physician relationship, the patient's consent is the trigger that allows treatment to take place. Seeking consent from patients is a major element of the everyday practice of almost every physician and is central to good medical practice. Legal and ethical requirements often overlap in medicine; this is particularly true for issues of consent. Many medical and surgical interventions are invasive and, under any other circumstances, could well lead to criminal charges. Surgery is a good example

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23 Bix 2009.

24 On the representation of incompetent patients; see § 7 of this chapter.

of this. This invasive treatment is accepted, though, because the expected benefit for the patient outweighs the inflicted harm. In this way, the consent given by the patient distinguishes legitimate medical treatment from acts of battery, assault or other ill-treatment.[25]

A patient's consent has to be given voluntary, without coercion by others.[26] However, this consent can only be given consciously and freely if the patient has been adequately informed of the medical treatment or procedure. The concept of informed consent has two key components: information and consent. As will be shown later, the information and consent components form the basis of valid informed consent.

Historically, the doctrine of informed consent was developed within the context of medical experiments on human subjects. As stated before, the Nuremberg trials were an important impetus for the idea that personal autonomy in health care needed adequate (legal) protection. As personal autonomy and informed consent are closely related, this also meant an important incentive in the development of the doctrine of informed consent. Because personal autonomy is often discussed in terms of informed consent, the literature often shows an overlap of ideas between these two concepts. In contrast to the idea of personal autonomy, that has developed gradually over several decades, the term informed consent as we know it today has developed more recently. After the Nuremberg trials, increasing awareness of the value of personal autonomy led to a renewed interest in the concept of consent in medical ethics. The term "informed consent" did not appear until a decade after these trials (which took place in 1946-1947), and was not scrutinised until the 1970s. In its early history, consent requirements were primarily aimed at minimising the risk of potential of harm. Since the mid-1970s, the primary justification for the use of informed consent has been to protect autonomous choice, in reference to autonomy rights of patients. Thus, the focus has shifted in recent years from the physician's obligation to disclose information, to the quality of patients' understanding and consent.[27] Informed consent is nowadays widely considered to be one of the fundamentals of health care. As Beauchamp and Childress state, "[s]ince the Nuremberg trials, […] biomedical ethics has placed consent at the forefront of its concerns".[28]

Currently, virtually all prominent legislation, rules and recommendations in the field of health care contain regulations and requirements concerning the realisation of (informed) consent before medical treatment can be performed. Both the ECtHR and the Convention for the protection of human rights and dignity of the human

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25 BMA 2004, p. 71.

26 In this, the two aspects of personal autonomy as defined by Beauchamp and Childress and used in this research that relate to the two concepts of freedom as introduced by Isaiah Berlin can be recognised. See § 2 of this chapter.

27 Beauchamp & Childress 2009, pp. 117-118.

28 Ibid., p. 117.

being with regard to the application of biology and medicine (hereafter: Biomedicine Convention), established by the Council of Europe in 1997, have acknowledged the concept of informed consent, for example (see § 8.4 of this chapter). Currently, in many countries in Western Europe, the rule that patients have to consent before medical treatment can be performed is codified. Still, as the BMA rightfully noted, seeking consent is not only a legal requirement or a procedure intended to protect physicians from legal challenge, but it must be considered "as a moral requirement, of which respect for others and their rights is the core".[29]

4.1. EXPLICIT, IMPLICIT AND PRESUMED CONSENT

Consent can be given in various forms; orally, in writing or simply by cooperating. The basic assumption of autonomy in health care is *explicit* (or express) consent. In this form, the patient explicitly expresses his consent. Mostly, this kind of consent is given orally. If there is reason to believe that evidence of this consent will be needed later, however, written consent is necessary. As will be shown later in this research, in hunger strikes, such written consent (in the form of an advance directive) can be important in determining the hunger striker's wishes for when he is no longer able to decide for himself.

Another form of autonomous consent is *implicit* (or implied or tacit) consent. In this case, the patient does not explicitly express his consent, but the consent is expressed silently or passively by omission. This kind of consent can be provided through, for example, actions such as offering an arm for the collection of a blood sample or opening one's mouth for medical examination. Consent can also be assumed to exist for a medical intervention that consists of a series of interventions. Consent for the medical intervention as a whole then covers the separate interventions. Of course, the more invasive the medical procedure the more important it is that the patient's explicit consent is obtained.

Another category that can be mentioned in this respect besides explicit and implicit consent is *presumed* consent. This is consent that is presumed on the basis of what is known about a particular person's choices or values. Nevertheless, studies show that the ideal of patient autonomy is far from universal. For this reason, consent should be based on an individual's actual choices, not on presumptions about the choices the individual would make.[30]

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29 BMA 2004, p. 71.

30 Beauchamp & Childress 2009, pp. 105-107. Patients from different ethnic backgrounds may have different needs and wishes as to what is disclosed and the way in which this information is disclosed. Beauchamp & Childress, in this respect, refer to American studies that have shown that differences exist between elderly persons from different ethnic backgrounds on the disclosure of the diagnosis and prognosis of a terminal illness and decision-making at the end of life.

Physicians should always seek explicit consent and be careful when assuming implicit or presumed consent.

4.2. ELEMENTS OF INFORMED CONSENT IN THE CONTEXT OF HUNGER STRIKE

Although the literal meaning may be clear, in the literature, no agreement exists on the definition of the concept of informed consent. Despite this lack of consensus on its definition, some authors have attempted to define the concept by specifying its constituent elements.[31] According to Beauchamp and Childress, in legal, regulatory, philosophical, medical and psychological literature, the following elements have been identified as the concept's analytical components: 1) competence, 2) disclosure, 3) understanding, 4) voluntariness and 5) consent.[32] Some writers conclude on the basis of these elements that a person can give informed consent to a medical intervention if (and perhaps only if) he is competent to act, receives a thorough disclosure, comprehends the disclosure, acts voluntarily and consents to the intervention. Beauchamp and Childress add two further components, and divide the total of seven into threshold, information and consent elements. This leads to the following scheme.[33]

I. Threshold Elements (Preconditions)
    1. Competence (to understand and decide)
    2. Voluntariness (in deciding)

II. Information Elements
    1. Disclosure (of material information)
    2. Recommendation (of a plan)
    3. Understanding (of 3. and 4.)

III. Consent Elements
    1. Decision (in favor of a plan)
    2. Authorisation (of the chosen plan)

The analysis by Beauchamp and Childress provides a clear overview of the steps in the process of the realisation of a patient's informed consent. Competence and voluntariness can be considered preconditions for informed consent. On the basis

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31 For an overview of examples of the different definitions that have been employed, see Leino-Kilpi et al. 2000, pp. 110-111. Some authors use the term "elements" to refer to these basic elements which constitute an understanding of the concept, as others refer to it as the "(analytical) components" of the concept. This makes no difference in the following analysis.

32 Beauchamp & Childress 2009, p. 120.

33 Ibid., pp. 120-121.

of provided information that is understood, decision-making activities can take place. This information should be sufficient, accurate and adequate. Preferably, this information is provided by the physician in attendance or the physician who is responsible for the medical treatment. As an outcome of this process, the patient decides to consent to or reject the medical treatment.

In my opinion, these elements provide a clear insight into the concept of informed consent and form an adequate framework for assessment of the question as to whether a valid informed consent exists. For this reason, I will further elaborate on some of these elements in the context of hunger strike in the order of the process of decision-making: voluntariness, disclosure and understanding (elements 2, 3 and 5).[34] Nevertheless, it must be noted that in my opinion, a hunger strike differs greatly from a normal medical intervention. For a normal medical intervention, the patient gives his consent before the intervention takes place. A hunger strike, on the other hand, can continue for a long period, in which several important medical decisions have to be made. These are not only decisions about whether to intervene or not, but also decisions about, for example, the intake of extra vitamins and liquids. Usually, the hunger striker's physical condition is checked regularly. At the same time, it is crucial that, at every stage of the hunger strike, all the relevant medical information is disclosed. The special nature of a hunger strike and its duration not only influence the element of disclosure, but also influence the threshold, information and consent elements and call for a continuing process of seeking informed consent.

4.2.1. Voluntariness

Beauchamp and Childress define voluntariness of decision-making in the sense that "a person acts voluntarily if he or she wills the action without being under the control of another's influence".[35] Voluntariness means that the patient should be free from influences that might affect the outcome of the decision. This is often a delicate matter in hunger strikes, as there will be many parties that influence the hunger striker. Also, hunger strikes are sometimes undertaken by groups. Of course not all influences exerted on the hunger striker are meant to control. What categories of influence can be distinguished? Authors focus on three categories of influence: coercion, persuasion, and manipulation. I will elaborate on these categories and their significance in hungers strike below.

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34 Because of its importance for the research topic, I will pay special attention to the issue of competence in § 6 of this chapter.

35 Beauchamp & Childress 2009, p. 132.

4.2.1.1. Categories of influence: coercion

The first category of influence that Beauchamp and Childress distinguish is that of coercion, which they describe as occurring "if and only if one person intentionally uses a credible and severe threat of harm or force to control another". Of course, not all threats constitute coercion. Whether coercion occurs depends on the subjective responsive of the person who is threatened: "Coercion occurs only if a credible and intended threat displaces a person's self-directed course of action."[36] As already stated, coercion of a hunger striker can be exerted by different parties. As shown in the definition, coercion has two main characteristics: there must be a credible and intended threat, and this threat must displace the person's self-directed course of action. In other words: in response to the threat, the person changes his mind about his own course of action. In my opinion, when a person is coerced, his voluntariness is impaired in such a serious way that no autonomous decision-making can take place. As also Beauchamp and Childress acknowledge, "coercion renders even intentional and well-informed behavior nonautonomous".[37]

Determining whether statements or actions qualify as a credible and intended threat can be a delicate matter. In hunger strikes, such a threat is most likely to come from the State or its authorities. In practice, the question will often occur whether, in exercising influence on the hunger striker by, for example, making certain statements, such parties make a credible and severe threat to the hunger striker. In other words: when is the hunger striker being coerced? To answer this question, many circumstances will be relevant, as evidenced, for example, by the truth of certain assertions. If it is true that it is possible to carry out force-feeding, this statement is correct and may as such be communicated to the hunger striker. Yet, if this statement is legally untenable, and thus false, it can be used to mislead the hunger striker, and would then constitute a credible and intended threat and constitute coercion, as well as manipulation (the third category of influence). In this situation, the hunger striker no longer voluntarily decides whether he stops his hunger strike. This example shows that a fine line exists between informing the hunger striker of the risks of his hunger strike and using this information to coerce the hunger strike to end his action. Designating acts as coercion is difficult, as this judgment is often strongly influenced by the factual situation and circumstances, as well as the subjective responses of the person who is influenced.

Coercion can also occur in group hunger strikes, such as those by members of the Red Army Faction in Germany in the 1970s and 1980s, the hunger strikes in Northern Ireland in 1980 and 1981, and the Turkish hunger strikes against the introduction of the new prison system from October 2000. In group hunger strikes, peer pressure can be exerted on individuals to participate and to continue

[36] Ibid., p. 133.

[37] Ibid.

the hunger strike. In such cases, it can be recommended to separate the hunger strikers in order to examine individually whether it is their own free will and their own choice to go on hunger strike and to continue it. This can be a delicate matter. Not only with group hunger strikes, but also with individual hunger strikers can a hunger striker be forced to begin or to continue his strike by persons around him, for example other prisoners or detainees. For this reason, it is important that when assessing voluntariness of a hunger striker, the physician speaks to the hunger striker in private – out of earshot of other people – in order to the assess the voluntariness of the person involved.[38]

4.2.1.2. Categories of influence: persuasion

The second category of influence is that of persuasion. According to authors, in persuasion "a person must come to believe in something through the merit of reasons another person advances".[39] In health care and health-related issues, much advice is given to patients. Patients usually assign great authority to this and other recommendations and advice by the physician. In this way, the physician involved may exercise a strong influence on the patient's decision-making process. As also shown in the list of elements outlined above, the recommendation (of a plan) by the physician is part of the process of seeking informed consent. This recommendation can play an important role in the patient's decision-making process. If the physician is convinced that a certain treatment is in the best interest of the patient he may even persuade the patient to act or decide in a certain way. (I will elaborate on the issue of paternalism in § 5 of this chapter.)

Not only is the physician in a position to strongly influence, and maybe even persuade or coerce the patient to decide in a certain way. The hunger striker will also be influenced not only by people within the custodial setting (the custodial authority, staff, guards, physicians, or other prisoners or detainees), and by outside sources (for example family and friends, or peer groups such as people from the same ethnic group or religious or political party to which the hunger striker belongs, or other parties surrounding the hunger striker). This influence may come in subtle as well as obvious ways. Often, many of these parties will attempt to persuade him to stop the hunger strike to prevent serious harm. Other parties may also attempt to persuade the hunger striker to continue his strike to exercise extra influence on persons or organisations with decision-making power. This influence may become increasingly intense, especially if the hunger strike continues. In my opinion, persua-

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38 Cf. Article 13 of the WMA Declaration of Malta on Hunger Strikers. Adopted by the 43rd World Medical Assembly Malta, November 1991, editorially revised at the 44th World Medical Assembly Marbella, Spain, September 1992, revised by the WMA General Assembly, Pilanesberg, South Africa, October 2006.

39 Beauchamp & Childress 2009, p. 133.

sion is a form of influence that is inextricably bound up with the hunger striking process because of the multitude of parties that are involved and the influence that these parties want to exercise over the hunger striker. Persuasion is a form of influence that, in principle, does not impair the element of voluntariness. Coercion, in contrast, as shown above, does impair this element. Gillet notes in this respect that "persuasion aims to enlist the patient's decision by providing information and coercion aims to manipulate the patient's decision by influences which undermine independent reasoning".[40] The distinction between coercion on the one hand and persuasion on the other is not always clear-cut and can cause practical dilemmas when assessing the hunger striker's voluntariness.

4.2.1.3. Categories of influence: manipulation

This third category covers several forms of influence that are neither persuasive nor coercive.[41] In health care and health-related matters, information can be used to manipulate the patient. Information can be rendered in such a way that it alters a patient's understanding of a situation or makes him decide to act in a certain way. To this end, the information itself may be manipulative, but also the manner in which the physician presents information may have a manipulating influence on the patient. Manipulation thus not only affects the element of voluntariness, but also the element of understanding. Beauchamp and Childress mention as examples of manipulation: lying, withholding information and exaggerating with the object of misleading persons.[42]

It can be concluded that all three above-mentioned categories of influence threaten the concept of informed consent. In principle, persuasion does not infringe on the element of voluntariness. Yet, if a patient's decision is subjected to coercion or manipulation, the element of voluntariness is violated and there is no valid informed consent. The three categories of influence are closely intertwined, and often difficult to separate them, chiefly in the context of a hunger strike. Afterwards it is often hard to indicate what specific kind of influence has been exerted or to prove whether a patient has been persuaded, coerced or manipulated. As a result, the element of voluntariness is almost constantly at stake during a hunger strike. For this reason, it is an important, but also difficult task for the physician to ascertain that the hunger striker's decisions are made voluntarily.

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40 Gillet 1989, p. 118.

41 Beauchamp & Childress 2009, p. 133.

42 Ibid., pp. 133-134.

4.2.2. Disclosure

Disclosure of material information is the first of the information elements. Disclosure of information is a crucial element in informed consent, as it provides an adequate basis for decision-making. In medical cases, it is the physician who decides what information he discloses to the patient. The element of disclosure, as well as the element of understanding, is closely connected to what is often considered to be the essential aspect of informed consent: the information aspect. Before answering the question of the level of understanding that is required to give valid informed consent, the question of what information has to be provided must be addressed.

In American law, three standards have been developed to determine the nature and quantity of information that should be disclosed. First, the "professional practice" standard requires that the patient should be given as much information as is customary in medical practice. The physician should disclose as much information as any other "reasonable" physician would disclose under the same circumstances. Secondly, the "objective" or "reasonable person" standard has been introduced more recently and requires that the patient is given the information that any "reasonable person" in the same situation would find relevant and necessary to enable him to make an informed decision. Thirdly and finally, the "subjective" standard concentrates on the needs of a specific patient rather than on that of the hypothetical reasonable person. Opinions on what standard of disclosure to use differ from country to country. In the UK, the "professional practice" standard is mostly used, in the US, the "reasonable person" standard, and in Germany, the "subjective standard".[43]

All these standards face practical and theoretical problems. In my view, valid informed consent requires that the physician should provide the information that is necessary for the patient to make his decision. It is hard to say in general terms what information is essential; this depends on the specific situation and the patient involved. In general, it can be said that the physician should give as much information as is necessary to meet his professional obligation to provide the best care for the patient, and to respect the patient's autonomy and his right to self-determination. In practice this means that when a patient is confronted with decisions concerning medical treatment, he should receive all relevant information on his state of health, the diagnosis, prognosis, the nature and purpose of the intervention, the effects, risks and benefits of the proposed form of treatment, as well as on alternative forms of treatment. Information on the possibility of no treatment should also be provided. The information must be clear and delivered in a way suitable for the person who is to undergo the intervention. It goes without saying that this information must be true and accurate.

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[43] Schermer 2001, pp. 27-28.

In the case of a hunger strike, this means that the physician must inform the potential hunger striker of all relevant aspects of his decision to go on hunger strike, which includes information on his physical condition, the physical consequences that can be expected (the prognosis), the possibility of reversible as well as irreversible harm, the ways in which intervention can take place and at what moment, the medical risks of such an intervention, the possibility and consequences of no intervention, and the possibilities of medical assistance during the hunger strike. The physician must also discuss the possibility of intervention if such a procedure is to be considered, and must also explore the possibility of administering extra vitamins or liquids. Allen and Reyes note that if the hunger striker suffers from pre-existing conditions, such as a stomach or duodenal ulcer, or has a heart condition, he should be informed about the increased dangers of going on hunger strike, since these medical conditions will most probably create acute problems which will need acute care and will necessitate the hunger strike to end.[44]

4.2.3. Understanding

Understanding is the last of the information elements. It refers back to the third and fourth elements, disclosure and recommendation (of a plan). On the basis of the provided information a patient is provided with a complete description of the medical intervention and its consequences. Based on his medical expertise, the physician recommends one or more actions. For valid informed consent, it is not enough that the patient receives this information and any recommendation, he also has to *understand* them. Understanding can be problematic in the realisation of informed consent. There are many reasons for a limited understanding on the part of the patient, such as illness, irrationality or immaturity. Beauchamp and Childress state that "persons understand if they have acquired pertinent information and have relevant beliefs about the nature and consequences of their actions".[45] Accordingly, the patient does not have to understand every detail of the medical treatment; it suffices if he understands the essential features of what he is consenting to. It can be difficult for a physician to make sure that a patient understands the information that is provided. In this respect, it is important that continuing conversation and discussion takes place between the patient and physician to make sure that the patient is provided with all the relevant information on the medical treatment and that he also understands all this information. Because of this interactive dialogue between the physician and patient, informed consent is sometimes referred to as "shared decision-making", especially when medical decision-making is a long and ongoing process, such as in the case of a hunger strike.

44 Allen & Reyes 2009, p. 198.

45 Beauchamp & Childress 2009, p. 127.

4.3. INFORMED REFUSAL

As stated earlier, informed consent implies a right to refuse; if patients are entitled to informed consent, it follows that they also have the right to decline such treatment. Annas noted that if this were not the case, the right to decide whether or not to undergo treatment would become a meaningless, equivalent to a "right to agree with your doctor".[46] On the basis of informed consent, competent patients are also entitled to refuse treatment, even when this treatment would clearly benefit their health. According to Beauchamp and Childress, the elements of informed consent includes the possibility of *informed refusal.*[47] Yet, in my view the threshold and information elements do indeed remain the same, but the content of the information that is to be provided to the patient differs. Although in procedures of informed consent, information about the possibility of non-treatment is also to be provided, in case of a refusal, more emphasis must be placed on the consequences of this decision. This also includes the question of whether the decision not to be treated has to be respected at all times. If there are possibilities for the physician to overrule this decision, the physician must inform the patient. This also gives the patient the possibility to take additional steps, such as drawing up a declaration of intent.

The term force-feeding implies that the hunger striker does not consent to being fed. For this reason, as already noted in § 3, it is not so much the concept of informed consent, but the concept of informed refusal that is involved. For this reason, the terms informed consent and informed refusal will both be used in this study.

4.4. EXCEPTIONS TO INFORMED CONSENT AND REFUSAL

As has been shown, the concept of informed consent is of major importance in contemporary health care. Below, I will go into the exceptions to the requirement of informed consent (and accordingly also informed refusal) that have been developed in the literature and their relevance to the matter of hunger strikes. With this, it is demonstrated that the concept of informed consent is not an absolute principle. Exceptions can be grouped into four categories.

The first category of exceptions are the emergency situations. It may be clear that sometimes emergency situations occur in which the patient is unable to give consent, to refuse or to receive information, because he is unconscious or because there is no time to speak to the patient as immediate medical intervention is

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46 Annas 2004, pp. 277-278.

47 Beauchamp & Childress 2009, pp. 120-121. Category III is then to be read as "Refusal Elements" and "6. Decision (in favor of a plan)" changes into "6. Decision (against a plan)". Element "4. Recommendation (of a plan)" in informed refusals becomes of minor importance, as the patient has already made up his mind about further treatment. Besides this, an informed refusal will not contain the element of "7. Authorization (of the chosen plan)".

required. In emergency situations, the physician will proceed without the patient's consent to prevent serious or irreversible physical harm. Such an intervention can be justified, in the words of Dworkin, because the physician acts to "preserve the possibility of future autonomous action".[48] When the patient regains consciousness and is capable of understanding his situation, the physician must explain what has occurred and which medical procedures have been performed. The physician must furthermore explain, if necessary, what procedure (or procedures) will follow the emergency treatment. In this conversation, the physician must again make sure that all the relevant information is presented to the patient and that the patient he understands this information; he must again seek the patient's informed consent. Such emergency is not very likely to occur in hunger strike cases, as most hunger strikes are long and ongoing processes. Still, such emergency situation may occur when a physician takes over a case and the hunger striker is has already lost mental capacity so that there is no opportunity to discuss the individual's wishes regarding medical intervention to preserve life. This situation is governed by Article 17 of the WMA Declaration of Malta (see Ch. 5, § 2.2.2). According to this article, in such a situation, medical intervention cannot always be justified, since consideration needs to be given to any advance instructions by the hunger striker.[49]

The second category is that of implied consent, in the sense that consent can be assumed to exist. As described in § 4.1, in implied consent, the patient does not explicitly express his consent, but consent is expressed tacitly. In some medical procedures or examinations, consent is so clearly manifest or routine that no explicit consent has to be given. A physician should be cautious to assume implied consent, as a broad interpretation would open the door to abuse and misinterpretation. The basic assumption for valid informed consent therefore remains explicit consent. Implied consent is not very likely to occur in a hunger strike, because – as the definition implies – it is intended to serve as a form of protest. The very nature of this action indicates that the hunger striker makes clear what he wants and does not want (i.e. intervention in his actions).

The third category is the one of the so-called waivers. In the exercise of waivers, patients voluntarily relinquish their right to consent to treatment. Every patient has this right, but they choose not to exercise it. In this case, surrogate decision-making authority is transferred to the physician or to someone else. A patient may also ask not to be informed. Most patients do not waive all rights; patients who waive their right to make a decision may still want to be informed. If a patient waives his right to consent to treatment, the physician is no longer obliged to obtain the patient's informed consent before administering medical treatment. Patients may choose to waive because they are fully confident of and rely on the physician's medical skills and

[48] Dworkin 1988, p. 116.

[49] For the purposes of this research, the terms advance instructions and advance directives will be used interchangeably.

expertise. If the decision to waive this right is made according to the requirements of a valid informed consent (fulfilling the elements of competence, voluntariness, disclosure, etc.) this decision is to be respected. Nevertheless, a general practice of accepting waivers is risky, as "the general acceptance of waivers of consent in research and therapeutic settings could make patients more vulnerable to those who omit consent procedures for convenience, already a serious problem in health care".[50]

The fourth category of exceptions to informed consent is that of "therapeutic privilege". In therapeutic privilege, the physician withholds information because he thinks that providing certain information will be harmful or cause distress to the patient. It is called therapeutic privilege, because it is therapeutic for the patient, and a privilege because it allows exemption from a duty.[51] This therapeutic privilege is not undisputed. Withholding information from a patient means a severe infringement of informed consent, and therefore must be adequately justified. Whether a physician has justifiably invoked therapeutic privilege depends on the harm that is prevented in not informing the patient. It is generally considered to be unacceptable to withhold information because, without this information, the patient might take a decision that is not in his best interest. According to some, a physician may invoke therapeutic privilege if he fears that disclosure of certain information will have a harmful effect on the emotional state of the patient when the supposed harm is very likely to occur and would be very serious. Others argue that the withholding of information can never be justified, because it would undermine the trust in the physician and because the possibility of a waiver gives the patient the opportunity to decide for himself whether he wants to receive certain information.[52] Therapeutic privilege is not only disputed in the literature, but also different opinions and interpretations exist on national levels. As a result, it is difficult to draw up general rules concerning this delicate issue. In general, I agree with the first-mentioned view that therapeutic privilege can only rightfully be used by the physician when he foresees, based on a sound medical judgment, that the information concerned would cause serious harm to an unstable or severely depressed patient, and this harm is very likely to occur. Severe harm includes causing severe anxiety or stress or endangering life. Only in this exceptional case may the physician use therapeutic privilege. In all the other cases the need for the patient's informed consent prevails.

A separate category of exceptions to informed consent is that of the case of incompetent patients. Various authors list it as one of the categories of exceptions to informed consent. In my view, this is not a genuine category of exceptions. As has been shown, competence is one of the prerequisites of informed consent. If the patient is not competent, no valid informed consent can exist. If no valid informed consent exists in the first place, no exception can be created.

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50 Beauchamp & Childress 2009, p. 132.

51 Dworkin 1988, p. 118.

52 Schermer 2001, p. 34.

It can be concluded that the exceptions to the requirement of informed consent (and accordingly also informed refusal) that have been developed in the literature are not particularly relevant to hunger strikes. Besides the categories of exceptions on informed consent as outlined above, it can be argued that another category of exception can be formed by third parties' interests in setting aside this patient's right. As already shown in § 2 of this chapter, the principle of personal autonomy is not absolute, and has to be balanced against other moral principles, rights and obligations. It can be argued that this is also the case for informed consent, as an expression of the principle of personal autonomy. In the next chapters I will elaborate on the question of whether other people's or society's interest may play a role in deciding to apply forced medical treatment, more specifically force-feeding.

5. PATERNALISM

Paternalism ("a parent's behaviour towards his children") is not an exception to the rule of informed consent. Nevertheless, it also raises questions on personal autonomy and its limitations. There is strong tension between the concept of personal autonomy and the praxis of paternalism. Frequently both concepts are regarded as conflicting notions.[53] Paternalist arguments not only occur in health care, but are also used as a justification for other restrictions by the law such as the obligation to use seatbelts in cars, pedestrian crossings, anti-drug legislation and the prohibition of the sale of alcohol to minors. In all of these cases, autonomy is restricted, based on the idea that persons are better off, or would be less harmed, as a result of these rules. As has been shown, personal autonomy is not absolute. It can be limited when someone's behaviour may harm others (for example on the basis of Mill's harm principle, see § 2 of this chapter). In the paternalist view, not only harm to others, but also harm to oneself may be used to justify the restriction of personal autonomy.

Paternalism can be best described as "the interference of a State or an individual with another person, against their will, and justified by a claim that the person interfered with will be better off protected from harm".[54] Other definitions focus on the positive aspect of freedom and include, beside the prevention of harm, the fact that the interference must also be intended to benefit the promotion of well-being. This definition, however, focuses on a person's negative freedom, as it emphasises the interference of a State or an individual with another person against their will. The latter includes that the person involved does not consent to the action. This is not surprising, since the (often problematic) characteristic of paternalism is the fact that a person's wishes and desires are set aside, invoking the person's own best interest.

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53 This view is not undisputed. See, for example, Nys 2007, who argues that some instances of paternalism should be considered as expressions of autonomy.

54 <http://plato.stanford.edu/entries/paternalism/> (last accessed on 10 January 2012).

This element of "will" furthermore implies, in my opinion, an element of competence. A person can only act in a paternalistic way towards another person if the person whose decisions are overruled is competent to decide otherwise. Incompetence implies that a person is not capable of deciding for himself in a certain task. As will be shown in Ch. 2, § 7, decision-making is then delegated to another person or authority. If this person of authority acts beneficently towards someone, in my view, this behaviour cannot be qualified as paternalistic, as it does not infringe upon the other person's rights, so that it does not "interfere against his will". This also implies that when a person's wishes are not known (for example, if a person is unconscious), persons cannot act in a paternalistic way towards this person since they cannot be sure whether the interference is against the person's will.

It has been noted, as is also laid down in the above-mentioned definition, that the person who is interfered with should be better off protected from harm. This aspect is important, because many actions which are called "paternalistic" are in fact not. Many actions aim to avoid harm to others or even to prevent people harming themselves. Nys, Denier and Vandevelde mention as examples of such actions the use of force to make alcoholics and drug addicts sober up in various institutions where they are kept against their will, with the purpose of ridding the streets of these people, and not because it is for their own good.[55]

As suggested by the definition, paternalistic interference can be performed by the State or an individual, for example a physician or another health professional. Because of his medical expertise and knowledge, the physician has a position of authority over the patient. Obligations in health care are grounded on the principle of beneficence, which expresses the primary obligation in health care. Given this principle, physicians have to act for the (medical) benefit of their patients. Notwithstanding the rise of the principle of autonomy, the principle of beneficence is still one of the leading principles in health care; it is articulated, *inter alia*, in the Hippocratic Oath. Beneficence is one of the main principles behind the concept of paternalism. In matters concerning informed consent, paternalistic arguments not only influence categories of exceptions to the concept (such as therapeutic privilege), but also influence several threshold and information elements of the concept (particularly the elements of disclosure, understanding, and voluntariness). Paternalistic arguments can also be invoked in favour of force-feeding (see Ch. 4, § 3.9).

6. COMPETENCE

Besides voluntariness, the competence to understand and decide is considered, in the view of Beauchamp and Childress, to be one of the threshold elements, or preconditions, of informed consent and refusal. Because of its importance in the

[55] Nys, Denier & Vandevelde 2007, p. 13.

discussion, and the far-reaching consequences the determination of competence may have, also in the discussion on the use of force-feeding, in this section I will elaborate on the element of competence. Comparable legal terms for competence and incompetence are capacity and incapacity. There is a difference between the two sets of terms, however, in the sense that health professionals assess capacity and incapacity whereas courts determine competence and incompetence. Nevertheless, this distinction often breaks down in practice, as the determination of capacity by health professionals often has the same practical consequences as the determination of competence by a judge.[56] For this reason, in the following, unless specified otherwise, I will use the terms competence and incompetence to indicate an individual's capacity as assessed by both health professionals and the courts.

The idea of competence as a precondition for personal autonomy is not new. While Kant did not differentiate between competent and incompetent persons, Mill clearly stated that the harm principle only applies to "human beings in the maturity of their faculties". Therefore, it does not apply to "children, or young persons below the age of which the law may fix that of manhood or womanhood" and "those who are still in a state to require being taken care of by others". Mill does not consider these groups of people "capable of being improved by free and equal discussion".[57] This distinction is comparable to what would nowadays be called competent and incompetent persons. The relevance of the issue of patient's competence has increased, as the concepts of personal autonomy and informed consent have gained more weight in the last decades.

The question of whether persons are competent often arises in situations in which the person involved is on the verge of making one or more important decisions. In most cases, these are decisions in which those surrounding the person involved doubt whether he is making the right decision, because he is likely to make a choice contrary to what is commonly considered to be in his own best interest. Physicians and other health personnel, but also family, friends and acquaintances may express doubts on the mental capabilities of the person involved. Because of the focus on decision-making, competence is often also called "decisional capacity" or "decision-making capacity". The question of a person's competence not only arises in decisions concerning health care and health related issues, but also occurs in other contexts, such as when a person draws up a contract or his will. For the purposes of this study, only competence in the medical context will be discussed.

In health care and health related issues, the question of competence is crucial because, if a person is incompetent, his rights to make his own decisions will be constrained or may even be withdrawn. Competence can be impaired as a result of mental retardation, brain damage from trauma or a mental illness. Health professionals' judgments of a patient's incompetence may lead them to override his

[56] Beauchamp & Childress 2009, p. 111.

[57] Mill 1863, p. 24.

decisions, to turn to surrogates for decision-making, to ask the court to appoint a guardian to protect his interests, or to seek his involuntary institutionalisation. If a court establishes legal incompetence, it appoints a surrogate decision-maker with either partial or full authority over the incompetent individual. In this way, competence plays an important role in determining whether a patient's wish is to be respected or may be ignored. Referring to its role as a precondition for valid consent, competence can be said to "serve a gatekeeping role" for, *inter alia*, informed consent and informed refusal.[58]

6.1. DEFINITION

How can competence be defined? Notwithstanding the importance of the concept, the definition of competence is still subject to discussion and debate. Also, legal standards of competence may vary across jurisdictions. Both Appelbaum and Grisso have formulated a conceptualisation of the concept according to four criteria that embody the ability 1) to communicate a choice, 2) to understand the relevant information, 3) to appreciate the medical consequences of the situation, and 4) to discuss treatment choices.[59] Nowadays, this conceptualisation is internationally used as a point of reference, and many other authors refer to these criteria, although sometimes in slightly different wording.[60] According to these criteria, a patient who can clearly communicate his choice, understands the information about his condition, appreciates the consequences of his choices and can weigh the relative risks and benefits of the options, can be considered competent to make a treatment decision.

Competence is always task-related; one can be competent to perform a certain task, but this does not imply competence to perform *any* task.[61] Accordingly, Buchanan and Brock argue that "the statement that a particular individual is (or is not) competent is incomplete. Competence is always competence *for some task*: competence *to do something*. The concern here is with competence to perform the task of making a decision."[62] This may lead to the fact that a person may be competent to make a decision at a particular time, under certain circumstances, but incompetent to make a decision, or even the same decision, under different circumstances. Decision-making capacity can also be influenced by temporary factors such as

58 Beauchamp & Childress 2009, p. 111, and Faden & Beauchamp 1986 pp. 287 ff.

59 Appelbaum 2007.

60 Ruissen, Meynen & Widdershoven 2011, p. 405 and 411. Authors also note that the four criteria as formulated by Appelbaum and Grisso have been translated into specific questions for the patient in the MacCat, which is regarded in international literature as the standard concerning the conceptualisation of competence (p. 409).

61 Schermer 2001, p. 34.

62 Buchanan & Brock 1990, p. 18.

pain, shock or medication. Only in very few cases can people be considered fully incompetent, for example, when they are permanently unconscious. In most cases people are declared incompetent for only a limited range of decision-making tasks. It may happen, for example, that a patient diagnosed as slightly mentally disabled may not handle financial affairs because of his credulity, may nevertheless be fully capable of indicating whether he consents to certain medical interventions. Even within health-care matters, patients may be competent to make some decisions, but incompetent to make others. It can be concluded that determining a person's competence is to establish his capacity to make a particular decision at a particular time under specific circumstances. It should be repeated, in this context, that competence may change over time, since abilities and capacities may also change over time. Moreover, persons can be said to possess different levels of competence, because most abilities and capacities contributing to competence can be possessed in varying degrees.[63]

In most Western countries, the law assumes that adult persons (and sometimes children who meet certain criteria) are competent and, in this way, are capable of making their own health care decisions. Young children, the largest group of incompetents, are considered to be so because of their immaturity. The age at which children are declared competent varies from 16 to 18 years in most Western countries. Until this age, they are represented by their parents.[64] Article 6 of the Biomedicine Convention notes in this respect that "[w]here, according to law, a minor does not have the capacity to consent to an intervention, the intervention may only be carried out with the authorisation of his representative or an authority or a person or body provided for by law. The opinion of the minor shall be taken into consideration as an increasingly determining factor in proportion to his or her age and degree of maturity."[65] In this way, the personal autonomy of the minor is taken into account.

In the literature, much has been written on the issue of competence, its standards and criteria for its assessment.[66] For the purpose of this research, I will not elaborate on these issues, but will only consider the role of competence in hunger strikes, and the possibilities of surrogate decision-making for incompetent patients.

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63 Schermer 2001, p. 34, and Buchanan & Brock 1990, p. 18.

64 For a discussion of minors and competence, see Buchanan & Brock 1990, pp. 215ff.

65 Convention for the protection of human rights and dignity of the human being with regard to the application of biology and medicine: convention on human rights and biomedicine. Oviedo, 4 April 1997. I will elaborate on the Biomedicine Convention and informed consent and refusal in § 8.4 of this chapter.

66 See, for example, Welie 2008.

6.2. COMPETENCE IN HUNGER STRIKES

As shown above, adult persons are competent, unless demonstrated otherwise. This idea is based on the concept of respect for personal autonomy. Although competence may only extend to certain fields of decision-making, may vary over time, and can be possessed in varying degrees, a patient is either competent or incompetent. What is the relevance of competence in hunger strikes?

As stated above, the question of whether persons are competent often arises in situations in which the person involved is on the verge of making one or more important decisions, and he is likely to make a choice contrary to what is considered to be in his own best interest. The decision to go on hunger strike is such a decision. Refusal of food and (medical) treatment may cast doubt on a person's competence. Although the decision to go on hunger strike is a drastic decision with far-reaching consequences for the person involved, this does not mean that a hunger striker is by definition incompetent. The judgment on competence is regardless of whether a certain decision is sensible or not. After all, the determination of competence is not solely concerned with the outcome of a decision; it is concerned with the decision-making process. Buchanan and Brock, in this respect, note that "a refusal of treatment in itself is not proof or even evidence that a patient is incompetent".[67] This is the same for hunger strikes. Just like other patients, hunger strikers are, on the basis of personal autonomy, in principle free to decide in matters concerning their body, and to pursue their own good as they perceive it. They may decide on whatever basis they desire, and decisions can still be valid, even though they seem irrational, less than optimal, or even foolish to others. Hunger strikers, just like other adult persons, are assumed to be competent, unless demonstrated otherwise. Still, the decision to refuse food may trigger a competence assessment. An early assessment of competence is crucial in determining whether food refusal qualifies as a hunger strike or not (after all, only competent persons can be hunger strikers, see Ch. 1, § 2.5). The determination of competence is not only important at the beginning of a hunger strike, at certain moments during the hunger strike, the hunger striker's competence will also need to be assessed. The far-reaching consequences the hunger strike has, and its often rapidly evolving nature, demands continued assessment of competence. Besides that, an analysis of the legitimacy of force-feeding incompetent prisoners and detainees on hunger strike invokes different considerations than is the case for a competent hunger striker. For this reason, formal assessment by a psychiatrist and ongoing psychiatric evaluation must be undertaken during the hunger strike.[68] In this respect, it must be noted that because of the fact that competence is always task-related (as noted above), where in this research the term

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67 Buchanan & Brock 1990, pp. 85-86.

68 Crosby, Apovian & Grodin 2007, p. 563. The importance of this (ongoing) psychiatric assessment is stressed by the WMA Declaration of Malta (see Ch. 5, § 2.2.2).

"competent" or "incompetent" prisoner or detainee in the context of a hunger strike is used, this competence – unless indicated otherwise – always refers to the decision to stop eating/refuse food.

In prolonged hunger strikes, there will inevitably come a moment when the hunger striker becomes incompetent, e.g. becomes comatose. For this reason, it is very important that before this time, when the hunger striker is still competent to decide, important decisions concerning medical interventions have been made. Before this moment, however, incompetence may also occur as a result of a prolonged food refusal. A study of South African hunger striking prisoners showed that 77% of the hunger strikers were clinically depressed at the time of their admission to hospital.[69] Physicians and other parties involved should be alert to signs of depression, as a diminished appetite can be one of its symptoms. The presence of a mental illness, however, does not mean *ipso facto* that a hunger striker is incompetent to make decisions on, *inter alia*, pursuing the hunger strike.[70] Although a mental illness is not in itself proof of incapacity, it can, in my opinion, constitute a reason for further investigation concerning the patient's mental capacity, especially when making such a drastic decision as to go on hunger strike. Many hunger strikers experience emotional instability during their hunger strike. When determining a hunger striker's (in)competence, it is crucial that he understands the nature and consequences of the hunger strike. A competence assessment will be needed to establish whether the hunger strike is a realistic response to a certain situation, or a reflection of a form of mental illness that impairs the prisoner's or detainee's competence. Accordingly, the doctor or psychiatrist must ensure that the hunger striker understands the potential health consequences of his actions, and evaluate his specific competence to decide to refuse food in light of that understanding.[71]

Sometimes hunger strikes are undertaken by minors. Hunger striking in minors (on occasion very young children) sometimes occurs when large groups of asylum seekers protest against the rejection of their asylum application. Minors, however, can also start a hunger strike while in a treatment centre, a remand home or a detention centre for minors. Older children, for example of 16 or 17, can sometimes make a conscious decision to begin a hunger strike. Hunger strikes by minors can evoke different considerations with regard to the question of force-feeding. The hunger striker's minority may influence the implication of the right to self-determination, the duty of the State and caretakers involved, and the determination of the hunger striker's competence.

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69 Kalk et al. 1993, p. 393. Kalk noted in this respect that the prisoner's helplessness during detention without trial, the uncertainty of its duration, and the failure of appeals to the courts for their release may have contributed to the high prevalence of psychological disturbances.

70 Kenny, Silove & Steel 2004, p. 237.

71 Fessler 2003, p. 244.

The final assessment of competence has far-reaching consequences and plays a crucial role in determining whether the hunger striker's wish must be respected or may be ignored. This assessment must be well-founded and provided with the necessary safeguards, such as the possibility for the hunger striker to request a second opinion by an independent physician or psychiatrist if the assessment is questioned by the hunger striker. Because of their professional training and their experience in the diagnosis of various psychological factors that may influence decision-making, psychiatrists are recommended to play a role in these competence assessments.

7. SURROGATE DECISION-MAKING FOR INCOMPETENT PATIENTS

Competence determination divides patients into two groups: competent patients, whose decisions must be respected, and incompetent patients, who do not have the possibilities or possess the capacity to perform a certain task and whose decision can be overruled. In the latter case, decision-making authority is delegated to someone who can take decisions on behalf of the incompetent person.

Buchanan and Brock have elaborated on the issue of surrogate decision-making.[72] The family of an incompetent individual is the principal decision-maker, except in emergency situations in which the family cannot be consulted without putting the patient at serious risk. In principle, a patient's family or spouse are considered to be his closest relations. They have the best knowledge of the incompetent individual's values and preferences and they are most concerned with the patient's well-being. Physicians are often suggested to act as the patient's decision-maker because of their medical expertise, but they often lack this knowledge.[73] In practice, physicians will often be tempted to take (minor) decisions on behalf of their incompetent patients, mainly to avoid time-consuming efforts to consult the patient's family. Still, the family is the principal surrogate decision-maker. National legislation may contain exceptions to the rule that surrogate decision-makers are not consulted in, for example, emergency situations. If family members have very different opinions or if there is no family, or the physician has doubts whether the surrogate is acting in the best interest of the person involved, a court can resolve the issue or appoint a surrogate decision-maker.

How should the surrogate decision-maker decide? As is also laid down in the Biomedicine Convention, the surrogate decision-maker must give his consent under the same conditions as the "original" decision-maker. To this end, the surrogate decision-maker must be given "appropriate information as to the purpose and nature of the intervention as well as on its consequences and risks" (Article 6.4 in

72 Buchanan & Brock 1990.

73 Buchanan & Brock 1990, pp. 134-141.

conjunction with Article 5). Besides, the incompetent patient must, as far as possible, take part in the authorisation procedure (Article 6.3). On the basis of respect for the incompetent patient's autonomy, his wishes and desires should be followed as far as possible. Based on this idea, three points of departure that surrogate decision-makers can use have been distinguished: pure autonomy or advance directive, the substituted judgment, and the patient's best interest.[74]

If an advance directive exists, this should be followed. An advance directive that is drawn up by the patient himself explicitly expressing his wishes and desires when he was competent to decide on the matter leaves no room for the surrogate decision-maker to decide. Sometimes doubts can exist on the validity of such advance directives. This can be caused by the fact that an advance directive was drafted a long time ago, so that the person may have changed his mind on this specific topic, or certain circumstances have changed over time that influence the decision-making. Furthermore, doubts can exist as to the patient's competence at the time of drawing up of the advance directive. Often advance directives are put in general terms and may be not completely clear on how to decide in specific situations. This point of departure for surrogate decision-making can only be used if the patient was fully competent to decide when he wrote the advance directive. If the patient is no longer competent, his previous wishes must be followed. Because of the great respect for his personal autonomy, this standard is also called the pure autonomy or precedent autonomy standard.[75] Advance directives are frequently used in hunger strikes to set out the hunger striker's wishes for when he is no longer to decide for himself.

Secondly, the substituted judgment standard requires that the surrogate decision-maker acts in the same way as the incompetent patient himself would have done, if he had been competent and was completely informed of his situation. The surrogate must place himself in the patient's shoes and decide from his perspective. If the patient has expressed wishes or desires before he became incompetent, the surrogate must follow these preferences. In situations that the patient has not foreseen and on which he has not expressed such preferences, the surrogate decision-maker must decide in line with the patient's general ideas and beliefs.[76] In my view, the substituted judgment can only reliably reflect the patient's wishes if the patient was once competent and the surrogate decision-maker knew the patient well enough to have a good understanding of the patient's values and beliefs.

Finally, the best interests standard requires that the surrogate decision-maker decides according to what he considers to be in the best interests of the incompetent patient. He may also look at the patient's previously expressed wishes and act according to these preferences. This approach resembles the substituted judgment

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74 These three standards are described by Beauchamp & Childress 2009, pp. 135-140, and Schermer 2001, pp. 41-42.

75 Beauchamp & Childress 2009, pp. 137-138.

76 Schermer 2001, pp. 41-42.

standard, but sometimes the patient's previously expressed wishes are not, or cannot be, known. The surrogate decision-maker must then decide what is in the patient's best interest: what promotes the patient's well-being best? To do so, he must weigh the risks and benefits of the proposed treatments, and choose the option that has the most benefits for the patient.[77] Choosing for another person on the basis of what one considers to be in his best interest may reflect a paternalistic approach. The surrogate decision-maker, however, does not act paternalistically as this behaviour does not infringe upon the incompetent patient's rights. Still, if the surrogate decision-maker does not act according to the patient's previously expressed wishes, he violates the patient's personal autonomy, even if he considers it to be in the patient's best interest.

This overview shows that there are different standards to serve as guidelines for surrogate decision-making. In my opinion, the pure autonomy standard is to preferred, since this is mostly in accordance with the idea of respect for the patient's personal autonomy, as the surrogate decision-maker decides according to the patient's previous expressed wishes. Inevitably, situations will occur which are not foreseen by, or not discussed with the patient. The substituted judgment standard can then serve as a guiding principle for surrogate decision-making. As the best interest standard is less connected to the patient's personal autonomy, this standard is only to be used when the advance directive and substituted judgment standard provide no basis for surrogate decision-making, such as in the case of never-competent patients.

8. EXPRESSIONS AND CODIFICATIONS OF PERSONAL AUTONOMY, THE RIGHT TO SELF-DETERMINATION AND INFORMED CONSENT

Respect for the patient's personal autonomy, the right to self-determination and informed consent and refusal are not only fundamental principles in modern medical ethics and health care, as shown in this chapter, but also addressed in European legal documents and case law. Below, I will go into these different documents and this case law to investigate the codification of these concepts.

[77] Schermer 2001, pp. 41-42, and Beauchamp & Childress 2009, pp. 137-140.

8.1. THE ECOMHR AND THE ECTHR ON PERSONAL AUTONOMY, THE RIGHT TO SELF-DETERMINATION AND INFORMED CONSENT AND REFUSAL

In the context of the Council of Europe, the most important document in the field of human rights is the ECHR, signed in Rome on 4 November 1950 (almost two years after the entry into force of the Universal Declaration of Human Rights). In order to ensure the rights and freedoms laid down in the ECHR, two bodies were originally established: the EComHR and the ECtHR. They were set up to ensure the observance of the engagements undertaken by Contracting Parties under former Article 19.[78] Until 1998, the EComHR was involved in two phases of the individual complaints procedure: first in deciding on the admissibility of the complaint, and secondly (if the case was declared admissible) in examining the merits. In the second phase, the procedure could end in a friendly settlement or some other arrangement. If no such settlement was reached, the EComHR stated its opinion in a report, and the case would be submitted to the ECtHR, which then would give the final decision on the merits. If a case was not submitted to the ECtHR, the Committee of Ministers gave the final decision on the merits.[79] This supervisory system was considerably changed by the entry into force of Protocol No. 11 on 1 November 1998. A new and permanent Court took the place of the EComHR and the ECtHR. Also, the role of the Committee of Ministers in the individual complaint procedure was dropped. The EComHR stayed in function until 1 November 1999 to handle the pending cases. The new ECtHR then handled the cases of the old ECtHR that were still pending on 1 November 1998.[80] Below, but also in the following chapters, I will go into cases by the EComHR, the old ECtHR, and the ECtHR as amended by Protocol No. 11.

On the basis of Article 46 (paragraph 1) ECHR, judgments of the ECtHR are unconditional legally binding upon the parties to them. Accordingly, a judgment in a particular case has only binding force for the parties concerned. Still, it is generally accepted that they are also binding on States not involved in the proceedings. In the literature, disagreement exists on the legal basis of this binding effect: some authors use a broad interpretation of Article 46, while others refer Articles 1 and 52 ECHR as a legal basis for this binding effect (under the former article the parties must secure the rights and freedoms in the ECHR to persons within their jurisdiction).[81] In this way, judgments in individual cases have a binding effect on all Council of Europe Member States), and States have to amend national legislation or practice to align with judgments in cases, including judgments to which they were not involved as a party.

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78 Van Dijk et al. 2006, p. 32 ff.

79 Ibid., p. 33.

80 Ibid., p. 36.

81 Van Kempen 2003, pp. 39-40, with references.

The principles of personal autonomy and the right to self-determination are derived from Article 8 ECHR. This contains the right to respect for private and family life and follows:

1. Everyone has the right to respect for his private and family life, his home and his correspondence.
2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

Article 8 ECHR protects the rights that are mentioned in the first paragraph. Article 8 ECHR contains the right to private life, which is mainly of importance in this study. In the case law of the EComHR and the ECtHR, no exhaustive interpretation of the concept has been given. The case of *Pretty* (concerning a 43-year-old woman suffering from a degenerative and incurable illness, who applied to the ECtHR asking for immunity from prosecution for her husband in assisting her to commit suicide) has been important in the development with regard to personal autonomy, the right to self-determination and informed consent and refusal, as will be shown below. In this case, the ECtHR ruled that:

> "The concept of 'private life' [as laid down in Article 8 ECHR] is a broad term not susceptible to exhaustive definition. It covers the physical and psychological integrity of a person […]. It can sometimes embrace aspects of an individual's physical and social identity […]. Elements such as, for example, gender identification, name and sexual orientation and sexual life fall within the personal sphere protected by Article 8. Article 8 also protects a right to personal development, and the right to establish and develop relationships with other human beings and the outside world […]. Although no previous case has established as such any right to self-determination as being contained in Article 8 of the Convention, the Court considers that the notion of personal autonomy is an important principle underlying the interpretation of its guarantees."[82]

According to the ECtHR, the concept of "private life" in Article 8 ECHR is a very broad concept, which covers a whole range of situations in the sphere of the physical and psychological integrity of a person. The ECtHR has not defined the concept, but only states that the notion of personal autonomy is an important principle underlying the guarantees of Article 8 ECHR. The physical and psychological/

[82] ECtHR 29 April 2002, *Pretty v the United Kingdom,* App. No. 2346/02, paragraph 61.

moral integrity of a person is therefore safeguarded under Article 8 ECHR. Besides, the State is under a positive obligation to secure its citizens their right to effective respect for this integrity.[83]

In the 2002 *Pretty* case, the ECtHR referred to the *notion* of personal autonomy as being an important principle underlying Article 8 ECHR. In this case, the ECtHR referred to personal autonomy as "the ability to conduct one's life in a manner of one's own choosing".[84] This may also include the opportunity to pursue activities that are physically or morally harmful or dangerous to the individual concerned (see Ch. 3, § 6.2.2.6). In my opinion, it is remarkable to see how this notion has gradually developed into a *right* to personal autonomy in the last decade. Judge Tulkens of the ECtHR, in her dissenting opinion in the case of *Leyla Şahin v Turkey*, spoke of a "real *right to personal autonomy* on the basis of Article 8", in referring to, *inter alia*, the *Pretty* case.[85] In 2007, the Grand Chamber of the ECtHR in the case of *Tysiac* mentioned that "'private life' a broad term, encompassing, *inter alia*, aspects of an individual's physical and social identity including *the right to personal autonomy*, personal development […]".[86] Since this moment, this right to personal autonomy has frequently emerged in case law in issues concerning Article 8 ECHR.[87]

A similar development took place in the last decade with regard to the right to self-determination. However, in the *Pretty* case, the ECtHR stated that no previous case had established a right to self-determination. Three years later, in 2005, the ECtHR acknowledged that the right to self-determination, including elements such as names and gender identification, forms a part of the notion of personal autonomy as laid down in Article 8 ECHR.[88] In the 2008 case of *E.B. v France*, the ECtHR ruled that

> "The Court has, however, previously held that the notion of 'private life' within the meaning of Article 8 of the Convention is a broad concept which encompasses, inter alia, the right to establish and develop relationships with other human beings […], the right to 'personal development' […] or the *right to self-determination* as such [referring to the *Pretty* case]. It encompasses elements such as names […], gender identification, sexual orientation and sexual life, which fall within the personal

83 ECtHR 20 March 2007, *Tysiąc v Poland,* App. No. 5410/03, paragraph 107.

84 ECtHR 29 April 2002, *Pretty v the United Kingdom,* App. No. 2346/02, paragraph 62.

85 ECtHR 10 November 2005, *Leyla Şahin v Turkey,* App. No. 44774/98 (Grand Chamber).

86 ECtHR 20 March 2007, *Tysiąc v Poland,* App. No. 5410/03, paragraph 107, emphasis added.

87 See, e.g., ECtHR 10 April 2007, *Evans v the United Kingdom*, App. No. 6339/05 (Grand Chamber), paragraph 71, and ECtHR 7 May 2009, *Kalacheva v Russia,* App. No. 3451/05, paragraph 27.

88 "*Le droit d'entretenir des relations sexuelles découle du droit de disposer de son corps, partie intégrante de la notion d'autonomie personnelle*." ECtHR 17 February 2005, *K.A. and A.D. v Belgium,* App. Nos. 42758/98 et 45558/99, paragraph 83 (available in French only).

> sphere protected by Article 8 […] and the right to respect for both the decisions to have and not to have a child.[89]

The ECtHR here clearly speaks of a right to self-determination as such, in relation to other personal rights. In 2011, the Grand Chamber of the ECtHR reiterated that

> "the notion of 'private life' within the meaning of Article 8 of the Convention is a broad concept which encompasses, *inter alia*, the right to establish and develop relationships with other human beings […], the right to 'personal development' […] or the right to self-determination as such [referring to the *Pretty* case]."[90]

Here, the ECtHR – again in reference to the *Pretty* case, where only a notion of self-determination was acknowledged – speaks of a right to self-determination. In my opinion, in these two cases, a right to self-determination is acknowledged. Although it most be noted that the right to self-determination as employed by the ECtHR is not understood in the same sense as in this research (see the above quote from *E.B. v France*), the development towards the recognition of a right to personal autonomy and the right to self-determination is proof of the growing recognition of the value of these principles in legal proceedings before the ECtHR.

The most important aspect of Article 8 ECHR for the question of force-feeding of hunger strikers is that under this article the physical and psychological/moral integrity of a person is safeguarded. Forced medical treatment interferes with the concept of the right to private life as laid down in Article 8 ECHR. In the *Pretty* case, but also in, for example, the *Botta* case, the ECtHR pointed out that the concept of "private life" in Article 8 ECHR encompasses both the physical and psychological integrity of a person.[91] A person's body is the most intimate manifestation of private life. As early as 1980, the EComHR ruled that the compulsory subjection to a medical or psychological examination or treatment, even when of minor interference, constituted an interference with the right to private life as laid down in Article 8 ECHR.[92] It can be concluded that Article 8 ECHR requires consent before medical intervention can take place. In the 2004 case of *Glass*, the ECtHR required that consent was given "free, express and informed".[93] Although the requirement of consent had been described earlier, the ECtHR used the term "informed consent"

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89 ECtHR 22 January 2008, *E.B. v France,* App. No. 43546/02 (Grand Chamber), paragraph 43 (emphasis added).

90 ECtHR 3 November 2011, *S. H. and Others v Austria,* App. No. 57813/00 (Grand Chamber), paragraph 80.

91 ECtHR 24 February 1998, *Botta v Italy,* App. No. 21439/93, paragraph 32. See also ECtHR 26 March 1985, *X and Y v* the *Netherlands*, App. No. 8978/80.

92 EComHR 13 December 1979, *X v Austria*, D&R 18, p. 154. Also: EComHR 10 December 1984, *Acmanne and Others v Belgium*, D&R 40, p. 254.

93 ECtHR 9 March 2004, *Glass v the United Kingdom,* App. No. 61827/00, paragraph 82.

(*accord éclairé* in French) for the first time in 2006.[94] Since then, this term has been frequently used by the ECtHR.[95] In November 2011, the ECtHR used it as a touchstone for the assessment of forced medical treatment within the scope of Article 3 ECHR, stating that informed consent serves as a prerequisite for medical treatment of mentally competent adult patients.[96] Where children are concerned, depending on the age, the right to give consent is "delegated" to the parents; medical treatment of the child cannot be performed without the consent of the parents.[97]

The ECtHR also elaborated on the issue of patient's refusal of treatment in the case of *Pretty*. The ECtHR noted in this case that, even though a refusal of treatment may lead to the death of the patient, it is to be respected, as compulsory medical treatment would violate a person's physical integrity. In the words of the ECtHR,

> "In the sphere of medical treatment, the refusal to accept a particular treatment might, inevitably, lead to a fatal outcome, yet the imposition of medical treatment, without the consent of a mentally competent adult patient, would interfere with a person's physical integrity in a manner capable of engaging the rights protected under Article 8 § 1 of the Convention."[98]

Article 8 ECHR thus requires both the patient's consent before a medical procedure can be performed and respect for the patient's refusal to be treated. The rights set out in the first paragraph of Article 8 ECHR are not absolute, but can be subject to restrictions as set out in the Article's second paragraph. I will deal with these restrictions in Ch. 3, § 6.2.2.6.

As already stated in § 4 of this chapter, currently virtually all prominent legislation, rules and recommendations in the field of health care contain regulations and requirements concerning the realisation of informed consent. I will not elaborate on deal with all these rules and regulations, but only deal with three documents in which the importance of personal autonomy, patient self-determination and informed consent and refusal is underlined. Although none of these three documents are legally binding, they can be considered as important guidelines in the patient-physician relationship.

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94 ECtHR 5 October 2006, *Trocellier v France,* App. No. 75725-01 (decision on admissibility).

95 See, for example, ECtHR 10 January 2008, *Kearns v France,* App. No. 35991/04, and ECtHR 13 May 2008, *Juhnke v Turkey,* App. No. 52515/99.

96 ECtHR 8 November 2011, *V.C. v Slovakia,* App. No. 18968/07, paragraph 110.

97 ECtHR 9 March 2004, *Glass v the United Kingdom,* App. No. 61827/00.

98 ECtHR 29 April 2002, *Pretty v the United Kingdom,* App. No. 2346/02 paragraph 63.

8.2. WMA DECLARATION ON THE RIGHTS OF THE PATIENT ON THE RIGHT TO SELF-DETERMINATION AND INFORMED CONSENT

The WMA Declaration on the Rights of the Patient (often referred to as the Declaration of Lisbon)[99] has codified some of the principal rights of the patient that the medical profession endorses and promotes. Under Principle 3, the Declaration explicitly acknowledges the patient's right to self-determination.

> 3. Right to self-determination
>
> a. The patient has the right to self-determination, to make free decisions regarding himself/herself. The physician will inform the patient of the consequences of his/her decisions.
>
> b. A mentally competent adult patient has the right to give or withhold consent to any diagnostic procedure or therapy. The patient has the right to the information necessary to make his/her decisions. The patient should understand clearly what is the purpose of any test or treatment, what the results would imply, and what would be the implications of withholding consent.
>
> c. The patient has the right to refuse to participate in research or the teaching of medicine.

According to the WMA, the right to self-determination can be defined as the possibility to make free decisions regarding oneself. On the basis of the right to self-determination, a competent adult patient has the right to consent to or to refuse treatment. To this end he should be adequately informed. The concept of informed consent is also relevant where it concerns unconscious patients (Principle 4). For unconscious patients, the physician must obtain informed consent from a representative. In case of a medical intervention that is urgently needed, consent of the patient may be presumed, unless it is obvious and beyond any doubt that he would refuse it. On the basis of Principle 5, in the case of minors or otherwise legally incompetent patients, although the consent of a representative is required in some jurisdictions, the patient must be involved in the decision-making process. Where able to make rational decisions, these decisions must be respected. If the patient's legally entitled representative forbids treatment which is, in the opinion of the physician, in the patient's best interest, he should challenge this decision in the relevant legal or other

[99] Adopted by the 34th World Medical Assembly, Lisbon, Portugal, September/October 1981, and amended by the 47th WMA General Assembly, Bali, Indonesia, September 1995, and editorially revised at the 171st Council Session, Santiago, Chile, October 2005. Like other documents of the WMA this document is not legally binding. More on the WMA, its history, members, aim and objectives; see Ch. 5, § 2.2.

institution. In case of emergency, the physician must act in the patient's best interest.[100] Principle 6 determines furthermore that procedures against the patient's will can only be carried out "in exceptional cases, if specifically permitted by law and conforming to the principles of medical ethics". Although the WMA only mentions informed consent as a part of the right to self-determination, Principles 5 and 6 are in my view also expressions of the idea of respect for the patient's right to self-determination.

8.3. UN ISTANBUL PROTOCOL ON INFORMED CONSENT

The 2004 Istanbul Protocol is a collection of international guidelines for the effective investigation and documentation of cases of torture, and other cruel, inhuman or degrading treatment or punishment.[101] It was adopted by the United Nations (hereafter: UN) in 1999. It is intended "to serve as international guidelines for the assessment of persons who allege torture and ill-treatment, for investigating cases of alleged torture and for reporting to the judiciary or any other investigative body".[102] The Istanbul Protocol contains a separate part that is dedicated to the issue of informed consent. Besides referring to the WMA Declaration on the Right of the Patient, in paragraph 63, under "Informed consent", it states that

> "An absolutely fundamental precept of modern medical ethics is that patients themselves are the best judge of their own interests. This requires health professionals to give normal precedence to a competent adult patient's wishes rather than to the views of any person in authority about what would be best for that individual. Where the patient is unconscious or otherwise incapable of giving valid consent, health professionals must make a judgement about how that person's best interests can be protected and promoted."

This paragraph stresses the importance of patient autonomy, the right to self-determination and informed consent in health care.

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100 Although this declaration was largely welcomed by the BMA, the British delegation took issue with the clauses that might run counter to living wills, such as the Principle that requires that doctors should always attempt to resuscitate people who have attempted suicide (Principle 8, under c). For this reason, in the controversial parts the word "should", and not "must" are used. Zinn 1995.

101 Istanbul Protocol. Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Office of the United Nations High Commissioner For Human Rights, New York and Geneva 2004.

102 Ibid., under "Introduction".

8.4. BIOMEDICINE CONVENTION AND INFORMED CONSENT AND REFUSAL

In 1977, the Council of Europe established the Biomedicine Convention, which forms an addition to the general human rights principles that are laid down in the ECHR.[103] It is a Convention, which means that it is legally-binding for those States that ratify or accede to it.

The Biomedicine Convention is a framework treaty: it sets out the most important principles, with additional standards and more detailed issues being dealt with in additional protocols.[104] Articles 5-9 deal with consent. Article 5 formulates as a general rule that

> "An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it. This person shall beforehand be given appropriate information as to the purpose and nature of the intervention as well as on its consequences and risks. The person concerned may freely withdraw consent at any time."

According to the Explanatory Report, Article 5 "affirms at the international level an already well-established rule, that is that no one may in principle be forced to undergo an intervention without his or her consent". Individuals must be free to give or refuse consent to any intervention involving their person. The Explanatory Report furthermore explains that the term "intervention" must be understood here in its widest sense, as covering all medical acts, in particular interventions performed for the purpose of preventive care, diagnosis, treatment or rehabilitation or in a research context.[105] According to the Explanatory Report, "[t]his rule makes clear patients' autonomy in their relationship with health care professionals and restraints the paternalist approaches which might ignore the wish of the patient".[106] Consent is considered free and informed if it is given on the basis of objective information from the responsible health care professional as to the nature and the potential consequences of the intervention and its alternatives, in the absence of any pressure from others. Here, some of the elements as described in § 4.2 of this chapter can be recognised.

Articles 6-8 define situations in which the exercise of the general rule as laid down in Article 5 may be limited. Article 6 concerns the protection of persons

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103 Convention for the protection of human rights and dignity of the human being with regard to the application of biology and medicine: convention on human rights and biomedicine. Oviedo, 4 April 1997.

104 Explanatory Report to the Biomedicine Convention, under 7.

105 Ibid., under 29.

106 Ibid., under 34.

not able to consent, and determines that where, according to law, a minor or an adult with a mental disability, a disease or for similar reasons, does not have the capacity to consent to an intervention, the intervention may only be carried out with the authorisation of his representative or an authority or a person or a body provided for by law. The opinion of the person involved shall be involved in the authorisation procedure. Article 7 concerns the protection of persons who have a mental disorder, and prescribes that they may only be subjected to interventions against their will when aimed at treating the mental disorder when, without such treatment, serious harm is likely to result in their death. Article 8 states that in emergency situations, no consent is required if the intervention must be carried out immediately for the benefit of the health of the individual concerned. Article 9 does not create an exception to the general rule of informed consent, but states that – also in an emergency situation – previously expressed wishes of a patient who is not, at the time of the intervention, in a state to express his wishes must be taken into account.

The requirement of informed consent as laid down in the Biomedicine Convention is binding for those States that have ratified or acceded to them. In the 2012 case of *V.C. v Slovakia*, the ECtHR acknowledged that, since the Biomedicine Convention was in force in respect of Slovakia at the time of the alleged forced medical treatment, informed consent had to be obtained before a medical procedure (i.e. sterilisation) could be performed.[107] In this way, the ECtHR legally observed Slovakian compliance to the Biomedicine Convention it had ratified in 1998.

9. CONCLUSIONS

In this chapter, the concepts of personal autonomy, the right to self-determination and informed consent in health care were explored. For the purpose of this study, the definition of personal autonomy by Beauchamp and Childress is adopted. They state that "personal autonomy encompasses, at a minimum, self-rule that is free from both controlling interference by others and from certain limitations such as an inadequate understanding that prevent meaningful choice. The autonomous individual acts freely in accordance with a self-chosen plan, analogous to the way an independent government manages its territories and establishes its policies." Similar to the definition used by the ECtHR, personal autonomy is considered a broad concept that, among other things, encompasses the right to self-determination, on the basis of which a patient has the right to decide for himself in issues concerning his health and his person.

Personal autonomy and the right to self-determination are the foundations of the concept of informed consent. Informed consent can be defined by specifying

[107] ECtHR 8 November 2011, *V.C. v Slovakia,* App. No. 18968/07.

its constituting elements: competence, voluntariness, disclosure, recommendation, understanding, decision and authorisation. In this chapter, I have discussed the elements of voluntariness, disclosure and understanding. Informed consent is counterbalanced by a right to refuse medical treatment: informed refusal. In the literature, exceptions to the concept of informed consent have been developed, which can be grouped into four categories; emergency situations, implicit consent, the so-called waivers and therapeutic privilege. These exceptions cannot be identically applied to the case of hunger strike, where informed refusals are mostly counterbalanced by third parties' interests that argue in favour of force-feeding. Paternalism is not an exception to the rule of informed consent, but can also raise questions on personal autonomy and its limitations.

The question of the patient's competence will often arise in informed refusals. Although a definition of competence is lacking, it is generally accepted that a patient who can clearly communicate his choice, understands the information about his condition, appreciates the consequences of his choices and can weigh the relative risks and benefits of the options, can be considered competent to make a decision on treatment. The far-reaching consequences that the hunger strike has, its often rapidly evolving nature, and its importance for the question of the legitimacy of force-feeding an ongoing assessment of the hunger striker's competence is required.

Respect for personal autonomy, the right to self-determination and informed consent are not only fundamental principles in modern medical ethics and health care, but are largely codified in European legal documents and case law. Besides, the ECtHR has acknowledged that the notion of personal autonomy is an important principle underlying the guarantees of Article 8 ECHR and has acknowledged the right to self-determination in its case law. The concept of informed consent is also acknowledged by the ECtHR and explicitly codified, *inter alia*, in the 1997 Biomedicine Convention of the Council of Europe.

CHAPTER THREE

THE PRISONER'S AND DETAINEE'S PERSONAL AUTONOMY AND RIGHT TO SELF-DETERMINATION IN HEALTH CARE

1. INTRODUCTION

In the previous chapter, the concept of personal autonomy, the right to self-determination and informed consent in health care were investigated in general terms. In this chapter, these notions will be explored with regard to prisoners and detainees. Because of the fact that patients who are deprived of their liberty, unlike patients in the community, are entirely dependent on the State to provide for their health care, I will first discuss the prisoner's and detainee's right to health care, including minimum standards for such health care, which have been formulated in international and European instruments. Secondly, I will briefly discuss an important issue for physicians working in custody; dual loyalties. In order to investigate whether the patients' rights as discussed in the previous chapter are equally applicable to prisoners and detainees, I will deal with the question of whether human rights apply to prisoners and detainees in full or whether they are inherently restrained. Fourthly, I will go into positive obligations for States that arise from Article 2 ECHR. Fifthly, I will examine international and European documents and review how is dealt with the matter of the prisoner's and detainee's informed consent and refusal in health care. States are in a position to impose restrictions on prisoners' and detainees' rights more stringently. Can these people's right to self-determination be restrained and, if so, on what grounds? Sixthly and finally, I will present conclusions on prisoners' and detainees' personal autonomy, their right to self-determination and informed consent.

2. HEALTH CARE IN PRISONS AND OTHER PLACES OF DETENTION

Just like other citizens, prisoners and detainees can find themselves in need of medical care. They may become ill whilst imprisoned, or they may suffer from a medical condition that already existed before they were detained, but the deprivation of liberty itself may also have a damaging effect on their physical and mental well-being. However, these persons cannot arrange their own health care; they are dependent on the State and the institutional authorities of the place where they are kept to provide them with the necessary medical care. Because of the many medical problems (such as drug and alcohol addiction, mental disorders and transmittable diseases), arranging adequate health and medical services in prisons or other places of detention is an important issue.

2.1. INTERNATIONAL STANDARDS

Since its inception in 1945, the UN has developed a number of international human rights instruments. It has enshrined human rights standards both in treaties and in other types of instruments, such as declarations, recommendations, guidelines and bodies of principles. Covenants, statutes, protocols and conventions have binding legal effect for the States that have ratified or acceded to them.[1] Formal treaties which have been ratified or acceded to by States and customary international law (general and consistent practice followed by States deriving from a sense of legal obligation) also have the character of binding law. Such treaties include the ICESCR, ICCPR and the Convention on the Rights of the Child.

Other instruments, such as declarations, guidelines, recommendations and bodies of principles, are not legally binding on States in and of themselves. Nevertheless, these instruments have moral force and provide practical guidance to States in their conduct. The value of these instruments rests on their recognition and acceptance by a large number of States and, even without binding legal effect, they may be seen as declaratory of principles that are broadly accepted within the international community.[2] These non-binding instruments, or non-binding provisions in treaties sometimes may form the special category of 'soft law'. 'Soft law' is not law, (it does not in itself constitute legal norms), but its importance within the general framework of international legal development is such that particular attention requires to be paid to it.[3]

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1 <http://www2.ohchr.org/english/law/> (last accessed on 17 January 2012).

2 OHCHR 2005, p. 7.

3 Documents such as recommendations, guidelines, codes of practice and standards may reflect a political intention to act in a certain way. Also, they may be significant in signalling an evolution

Many of these instruments contain stipulations to arrange adequate health care in prisons and other places of detention and underline the importance of a well-arranged and adequate health service, which is available for all those deprived of their liberty. International and European standards provide information on what is to be expected from health care services in prisons and other places of detention. Almost all of these documents underline the need for a well-arranged and adequate health service by emphasising that persons who are deprived of their liberty constitute a specific and vulnerable group.

2.1.1. A right to health care for prisoners and detainees?

In general, the increased international and European focus on the rights and protection of prisoners and detainees has developed from the adoption of generally applicable human rights charters. At the international level, the 1948 Universal Declaration of Human Rights[4] and the 1966 ICCPR provide a normative pattern for human rights law and proclaim a number of fundamental rights which, although they only make passing reference to them, are also applicable to persons deprived of their liberty.[5] Article 25, paragraph 1 of the Universal Declaration of Human Rights states that "[e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care". In addition, Article 10, paragraph 1, ICCPR states that "[a]ll persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person". The Human Rights Committee is the body of independent experts that monitors implementation of the ICCPR by its States Parties.[6] The Human Rights Committee, has ruled that "persons deprived of their liberty must not be subjected to any hardship or constraint other than that resulting from the deprivation of liberty; respect for the dignity of such persons must be guaranteed under the same conditions as for that of free persons" (like the ICCPR, the Human Rights Committee refers to persons deprived of their liberty in general, and not exclusively to prisoners). It furthermore added that "by arresting and detaining individuals [States Parties]

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and establishment of such guidelines, which may ultimately result in legally binding rules. Shaw 2008, pp. 117-118.

4 Adopted and proclaimed by the General Assembly of the UN on 10 December 1948. Although the Universal Declaration of Human Rights is not a legally binding document and cannot legally be enforced, it is considered "the cornerstone of UN activity" and it has marked influence upon the constitutions of many States and the formulation of subsequent human rights treaties and resolutions. Shaw 2008, pp. 279-280.

5 Murdoch 2006, p. 19.

6 I will elaborate on the supervisory task of the Human Rights Committee as well as their view on force-feeding of hunger strikers in Ch. 5, § 2.1.6.

take the responsibility to care for their life."[7] A lack of financial means by the State Party cannot reduce this responsibility.[8]

Article 12 of the ICESCR contains a right to an adequate standard of living which is relevant to the question of health care in prisons and other places of detention. It declares that "[t]he States Parties to the present Covenant recognize the right of everyone [therefore also prisoners and detainees] to the enjoyment of the highest attainable standard of physical and mental health." In the second paragraph of this Article requirements of States Parties to fulfil this right are described. In my opinion, Article 12 ICESCR formulates a right to health care for prisoners and detainees. (The Convention on the Rights of the Child (hereafter: CRC) has articulated a similar "right to health care" for children.)[9] The Committee on Economic, Social and Cultural Rights (hereafter: CESCR), the body of independent experts that monitors implementation of the ICESCR by its States Parties,[10] explicitly acknowledges in its General Comment No. 14 on Article 12 that "the right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation." The entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.[11] In General Comment No. 14, the CESCR also defines the legal obligations that States Parties have to fulfil in order to ensure the right to health at the national level. This legal obligation includes, *inter alia*, the obligation to refrain from denying or limiting equal access for all persons, including prisoners and detainees, minorities, asylum seekers and illegal immigrants.[12] In my opinion, it is not remarkable that the CESCR has given a broad interpretation of Article 12 of the ICESCR, as the article is formulated in very general terms.

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7 Human Rights Committee, view of 17 March 2006, *Brough v Australia,* Comm. 1184/2003.

8 Human Rights Committee, view of 26 March 2002, *Lantsova v Russia,* Comm. 763/1997. The Human Rights Committee already stated in 1981 that prisoners should be provided with necessary medical care: Human Rights Committee, view of 28 October 1981, *Setelich v Uruguay,* Comm. 063/1979.

9 In the CRC, children are defined as persons below the age of 18 years. Article 25 acknowledges "the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement". Convention on the Rights of the Child. Adopted and opened for signature, ratification, and accession by General Assembly Resolution 44/25 of 20 November 1989, entry into force 2 September 1990.

10 I will elaborate on the supervisory task of the CESCR as well as their view on force-feeding of hunger strikers in Ch. 5, § 2.1.5.

11 Substantive issues arising in the implementation of the ICESC, General Comment No. 14, E/C.12/2000/4, under 8 and 34.

12 Ibid., under 34.

Alongside the fundamental rights of all humans, prisoners and detainees have additional safeguards as a result of their status. When a State deprives people of their liberty it takes on the responsibility to look after their health, not only in terms of providing medical care, but also by establishing custodial conditions which promote the well-being of prisoners and detainees. In 1955, the UN Congress adopted the Standard Minimum Rules for the Treatment of Prisoners (hereafter: SMR).[13] The SMR have always been considered the most important international document in the area of prisons. Together with the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment of 1988 and the Basic Principles for the Treatment of Prisoners of 1990, they provide a set of standards and safeguards for the protection of the rights of prisoners and detainees. The SMR set out what is generally accepted as being good principle and practice in the treatment of prisoners and the management of prison institutions (see Principle 1). They also provide measures to safeguard prisoners' health, among other things, with regard to detention circumstances such as accommodation, work and education, recreation, and also medical services. Part I of the SMR covers the general management of institutions, and is applicable to all categories of prisoners, criminal or civil, untried or convicted, including prisoners subject to "security measures" or corrective measures ordered by the judge (Preliminary observation 4.1).[14] The SMR prescribe that these different categories of prisoners (and, in my definition, also detainees) must be kept in separate institutions or parts of institutions taking account of their sex, age, criminal record, the legal reason for their detention, and the necessities of their treatment (Rule 8). At every institution, there must be at least one qualified medical officer, and the medical services should be organised in close connection with the general health administration of the community or nation (Rule 22). Rule 25 determines that decisions about a prisoner's or detainee's health should only be taken on medical grounds by medically qualified people. The rules concerning medical treatment are included in the first part of the SMR, highlighting the importance of adequate medical treatment for persons who are deprived of their liberty, no matter the reason or legal title. Still, the SMR are not formulated as rights for prisoners and detainees. Accordingly, they do not phrase a right to health care for persons in custody.

Although the UN has not only focused on the treatment of adult prisoners and detainees, the SMR are not applicable to children. In general, the Beijing Rules (1985) provide guidance to States for the protection of juveniles' rights and respect for their

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13 UN Standard Minimum Rules for the Treatment of Prisoners. Adopted by the First UN Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its Resolution 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977.

14 Part II of the SMR contains rules applicable only to special categories; prisoners under sentence, insane and mentally abnormal prisoners, prisoners under arrest or awaiting trial, civil prisoners and persons arrested or detained without charge.

needs in the development of separate and specialised systems of juvenile justice.[15] In 1990, two other documents governing juveniles were adopted: the UN Guidelines for the Prevention of Juvenile Delinquency (the Riyadh Guidelines)[16] and the UN Rules for the Protection of Juveniles Deprived of their Liberty (the Havana Rules).[17] Together with the CRC, these two instruments emphasise that juveniles constitute a specific group with special needs in prisons and other places of detention. All these documents, especially the Havana Rules, stress the importance for juveniles to receive adequate physical and mental health care, preventive as well as remedial.[18]

Penal Reform International is an international NGO concerned with penal and criminal justice reform worldwide. In 2001, they published a handbook with an overview of the UN rules on prison conditions and treatment of prisoners for those working with prisoners or responsible for their care and treatment.[19] The term "prisoner" in this document is understood in the widest sense, since it states that "[t]his Handbook is concerned with the human rights of people in detention or in prison. These rights are derived from universal general human rights. They apply to every individual" (Article 1). Under 1, they explicitly state a "right to health" for all people deprived of their liberty.[20] A right to health is broader than a right to health care, as such a right to health in my opinion may not only include a right to adequate health care in prisons and other places of detention, but also a duty for the State and custodial authorities to, *inter alia*, guarantee healthy custodial conditions for prisoners and detainees.

Such a wider right to health is acknowledged in Rule 39 of the European Prison Rules[21] (as will be elaborated on in § 2.2.1 of this chapter), which determines that "[p]rison authorities shall safeguard the health of all prisoners in their care". The Commentary to these Rules states that Rule 39 has its basis in Article 12 ICESC. "Alongside this fundamental right, which applies to all persons, prisoners have additional safeguards as a result of their status." Accordingly, when a State deprives people of their liberty, it takes on the responsibility to look after their health in terms both of the conditions under which it detains them and of the individual treatment that may be necessary. According to the Commentary

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15 UN Standard Minimum Rules for the Administration of Juvenile Justice. Adopted by General Assembly Resolution 40/33 of 29 November 1985.

16 UN Guidelines for the Prevention of Juvenile Delinquency. Adopted by General Assembly Resolution 45/112 of 14 December 1990.

17 UN Rules for the Protection of Juveniles Deprived of their Liberty. Adopted by General Assembly Resolution 45/113 of 14 December 1990.

18 Articles 28 and 49-55.

19 Penal Reform International 2001.

20 Ibid., p. 5.

21 Council of Europe, European Prison Rules, Recommendation R (2006)2, adopted by the Committee of Ministers on 11 January 2006.

> "Prison administrations have a responsibility not only to ensure effective access for prisoners to medical care but also to establish conditions that promote the well being of both prisoners and prison staff. Prisoners should not leave prison in a worse condition than when they entered. This applies to all aspects of prison life, but especially to healthcare."

In Rule 39, the right to health care as laid down in Article 12 ICESC is extended, in a way that prison administrations must not only provide prisoners and detainees with necessary individual medical treatment, but also with adequate custodial conditions that promote their health and well-being. In this way, such a right to health not only provides for adequate health care services in prisons and other places of detention, but also protects prisoners and detainees against poor custodial conditions which cause physical or mental health suffering. This is in line with view of the ECtHR as illustrated in its case law, as will be shown in § 2.2.2 of this chapter. Although the ECHR does not contain a right to health care as such, it has ruled on health care issues, in relation to custodial conditions in the light of Articles 2 and 3 ECHR, which promote the right to life and prohibit torture, and inhuman or degrading treatment or punishment. In several cases, the ECtHR has ruled that, although more or less adequate medical treatment had been provided, poor custodial conditions, such as overcrowding, inadequate lighting and ventilation, impoverished regimes, poor hygiene conditions and state of repair of the cell facilities, can contribute to the finding that Article 3 ECHR has been violated.[22] The case law of the ECtHR and the reports by the CPT have strongly contributed to the development of minimum levels for adequate custodial conditions, by creating detailed standards for custodial conditions such as cell size, light and ventilation, hygiene and sanitary facilities (as will be elaborated on in § 2.2.4 of this chapter).

2.1.2. Equivalence of care

In 1982, the UN Resolution on the Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees against Torture, and other Cruel, Inhuman or Degrading Treatment or Punishment (hereafter: Principles of Medical Ethics) was adopted by the General Assembly.[23] This document applies broadly to all persons who are deprived of their liberty as illustrated in the SMR, as it does not only refer to prisoners, but in its title and text consistently refers to both prisoners and detainees. Principle 1 of the Resolution on the Principles of Medical Ethics imposes a duty on health personnel,

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22 See, for example, ECtHR 8 November 2005, *Alver v Estonia,* App. No. 64812/01, paragraph 56.

23 UN Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees against Torture, and other Cruel, Inhuman or Degrading Treatment or Punishment, UN Doc A/37/51, 1982.

particularly physicians, charged with the medical care of prisoners and detainees, "to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained." This is called the "equivalence of care" principle: prisoners and detainees have the right to a level of care equal to that which is provided to other citizens in a particular country.

In 1990, building on Principle 1 of the 1982 Resolution on the Principles of Medical Ethics, the General Assembly of the UN acknowledged in Principle 9 of the Basic Principles for the Treatment of Prisoners that "[p]risoners shall have access to the health services available in the country without discrimination on the ground of their legal situation."[24] Because of the repeated reference to, *inter alia*, the "long-standing concern of the United Nations for the humanization of *criminal justice* and the protection of human rights", "the concern of previous United Nations congresses on the *prevention of crime and the treatment of offenders*" and the "development of *penal policy and practice*", combined with the fact that the principles as formulated only seem to be applicable to the specific situation of prisoners, the Basic Principles for the Treatment of Prisoners document probably defines the term "prisoner" in the same way as in this study, as referring to a group of persons who are deprived of their liberty in connection with a suspected or proven criminal offence.[25]

The UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health has underlined this principle of equivalence, underpinning health in prisons and other places of detention by stating that "the duty to respect [protect and fulfil the right to the highest attainable standard of health] requires the State to refrain from denying or limiting equal access for all persons, including prisoners, minorities, asylum-seekers and illegal immigrants, to preventive, curative and palliative health services."[26]

It is not only UN instruments that express the idea that prisoners and detainees are entitled to the same level of medical care as other citizens. A similar idea is illustrated by the WHO. This is not remarkable, as the WHO is the directing and coordinating authority for health within the UN system. However, this acknowledgement of the equivalence of care principle is still an important signal for the 193 WHO Member States. The equivalence of care principle implies that prisons and other places of detention have to provide a standard of health care that is equivalent to that available within the rest of the community. According to the WHO, the term "prison" is intended to denote, as a minimum, institutions that hold people who have been

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24 UN Basic Principles for the Treatment of Prisoners, Adopted and proclaimed by General Assembly Resolution 45/111 of 14 December 1990.

25 Ibid., preamble, italics added.

26 Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, 17 January 2007, A/HRC/4/28, under 77 and 78. I will elaborate on the task and mandate of the UN Special Rapporteur in Ch. 5, § 2.1.8.

sentenced to a period of imprisonment by the courts for offences against the law. The institutions included in the term prison can vary between countries. However, the principles, approaches and technical advice can also be relevant to other forms of compulsory detention.[27] The equivalence of care principle implies the availability of a wide range of services, measured both by the nature and quality of care and by the availability and organisation of properly trained medical, nursing, pharmacy and technical staff.[28] To secure equivalence of care, among other things, the WHO emphasises the essential need for close links or integration between public health services and prison health care in its 2003 Declaration on Prison Health stating that "[p]enitentiary health must be an integral part of the public health system of any country". In the opinion of the WHO, this is essential, because

> "[i]n all countries of the world, it is people from the poorest and most marginalized section of the population who make up the bulk of those serving prison sentences, and many of them therefore have diseases such as tuberculosis, sexually transmitted infections, HIV/AIDS and mental disorders. These diseases are frequently diagnosed at a late stage. In addition, no country can afford to ignore widespread precursors of disease in prisons such as overcrowding, inadequate nutrition and unsatisfactory conditions."[29]

The WMA has also contributed to the development of an adequate prison health care system, in emphasising that sick prisoners should enjoy the same rights as other patients.[30] The WMA and WHO have both issued documents that are of importance for specific health care issues in prisons, such as the Guidelines on HIV Infection and AIDS in Prison, and the Declaration for the Prevention of the Spread of Tuberculosis and Other Communicable Diseases.[31] The equivalence of care principle is not only acknowledged in international human rights documents and proclaimed by international health organisations, but also an important topic for, for example, the CPT (see § 2.2.3). Besides, national and international non-governmental organisations such as Amnesty International, Human Rights Watch, the ICRC, and Penal Reform

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27 World Health Organisation 2007, p. xvi.

28 Murdoch 2006, p. 224.

29 World Health Organisation, *Declaration on Prison Health as Part of Public Health,* Moscow: 24 October 2003.

30 See, for example, Preamble under 7 of the Declaration of Edinburgh on Prison Conditions and the Spread of Tuberculosis and Other Communicable Diseases, adopted in October 2000. To my knowledge, the WMA has not elaborated on their definition of the term prisoner. Still, it is most likely that with this definition the broad category of persons who are deprived of their liberty are meant, i.e. prisoners and detainees.

31 WHO Guidelines on HIV Infection and AIDS in Prison. Issued in March 1993, Geneva & World Medical Association, Declaration of Edinburgh on Prison Conditions and the Spread of Tuberculosis and Other Communicable Diseases, adopted in October 2000.

International have also urged States to contribute to the development of an adequate system of health care in prisons and other places of detention.

Given the extreme health problems evident in prisons worldwide, the legal obligation of the State to safeguard the lives and well-being of people it holds in custody and the implications of poor prison health on overall public health, it can be argued that standards of prison health care that are merely equivalent to that in the community would in some cases fall short of human rights obligations and public health needs. For this reason, Lines argues in favour of moving beyond the concept of equivalent standards of health care, and promotes standards that achieve equivalent objectives instead. In some circumstances, meeting this new standard will even require that the scope and accessibility of prison health services are higher than that outside prisons.[32] Whether this is a realistic proposition will usually depend on a State's political priority and popular support.

2.1.3. Prohibition of torture and inhuman or degrading treatment and health care

Persons who are deprived of their liberty constitute a group vulnerable to human rights abuses. The risk of torture, inhuman or degrading treatment increases when prisoners or detainees are non-cooperative (such as in hunger strikes) or violent. Also, the prohibition of torture and inhuman or degrading treatment is particularly relevant in health care situations for several reasons. First of all, the lack of medical treatment in prison can violate human rights. As shown in the previous sections, the international human rights regime underlines the importance of well-arranged and adequate health care that is available in prison. A lack of such medical treatment, or the denial of such treatment, may rise to the level of torture and inhuman or degrading treatment. Besides, medical treatment in prison itself can be considered to constitute torture or inhuman or degrading treatment. In severe cases, torture can be performed in the name of health care, or abuse take place under medical supervision (in my opinion, medical treatment at the US Guantánamo Bay Naval Base qualifies as such, see Ch. 5, § 2.1.8). In this study, the question of whether force-feeding of prisoners on hunger strike can constitute such treatment is investigated. These examples show that health professionals may become involved in human rights abuses. Nevertheless, they can also play a vital role in *preventing* such situations from occurring. Health care professionals can play an important role in detecting physical and mental abuse as a result of situations of torture or inhuman or degrading treatment and investigate and report on such abuses.

Concern for the involvement of health professionals in situations of torture or inhuman or degrading treatment is expressed in, among others, the above-mentioned UN Resolution on the Principles of Medical Ethics. The second Principle prohibits health personnel, particularly physicians, committing torture or other cruel,

[32] Lines 2006.

inhuman or degrading treatment. This Principle is also clearly phrased in the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (hereafter: Convention against Torture).[33] Article 10, paragraph 1, of this Convention explicitly states that "[e]ach State Party shall ensure that education and information regarding the prohibition against torture are fully included in the training of law enforcement personnel, civil or military, medical personnel, public officials and other persons who may be involved in the custody, interrogation or treatment of any individual subjected to any form of arrest, detention or imprisonment". Article 11 furthermore notes that States Parties have to keep interrogation rules, instructions, methods, and practices as well as arrangements for the custody and treatment of persons subjected to any form of arrest, detention or imprisonment under systematic review, to prevent cases of torture. Accordingly, prisoners and detainees may not be tortured or subjected to cruel, inhuman or degrading treatment or punishment. The Committee Against Torture (hereafter: CAT) monitors the implementation of the UN Convention against Torture by its States Parties. In 2002, the Optional Protocol to this Convention was adopted, entering into force on 22 June 2006. This Optional Protocol obliges countries to set up, designate or maintain one or more visiting bodies for the prevention of torture and other cruel, inhuman or degrading treatment (a national preventive mechanism) at the domestic level. This Optional Protocol also created a system of regular visits to places where people are deprived of their liberty by a Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, a system that can best be compared with the CPT that exists on the European level.

A general principle for prisoners and detainees to be protected from torture, and not to be subjected to cruel, inhuman or degrading treatment or punishment can be found in Principle 6 of the 1988 Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment.[34] In line with this general principle for prisoners and detainees to be protected from torture, the third Geneva Convention (one of the four Geneva Conventions, first adopted in 1929, but updated in 1949) deals with the humane treatment of prisoners of war. All the Geneva Conventions contain stipulations which are aimed at protecting the human rights of victims of war by requiring that prisoners should be "treated humanely" and forbidding "cruel treatment and torture" and "outrages upon personal dignity, in particular humiliating and degrading treatment".

The UN have played an important role in the developing prisoner's and detainee's rights by not only codifying standards and safeguards against torture and inhuman

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[33] UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Adopted by General Assembly Resolution 39/46 of 10 December 1984, entry into force 26 June 1987.

[34] UN Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, 1988, under Principle 6.

or degrading treatment in several instruments, but also creating awareness of human rights amongst personnel working with prisoners and detainees. Since 1955, the Office of the UN High Commissioner for Human Rights (hereafter: OHCHR, formerly "UN Centre for Human Rights") has been engaged in assisting States in building and strengthening national structures that have a direct impact on the overall observance of human rights and the maintenance of the rule of law. In this context, the OHCHR has been involved in the training of personnel working in the area of administration of justice, *inter alia*, in the training of staff working with prisoners and detainees, such as the manual on human rights training for prison officials *Human Rights and Prisons*.[35]

2.2. EUROPEAN STANDARDS

Within Europe, the Council of Europe has fulfilled a leading role in the development of standards for the treatment of prisoners and detainees. The Committee of Ministers of the Council of Europe has issued several recommendations which relate to specific aspects of penal policy and practice, for example, on education in prisons and the management by prison administrations of life-sentence and other long-term prisoners, but has also issued recommendations that specifically govern health care in prisons. Relevant recommendations in this respect are, for example, the Recommendation Concerning the Ethical and Organisational Aspects of Health Care in Prison and the Recommendation Concerning the Criminological Aspects of the Control of Transmissible Diseases including AIDS and Related Health Problems in Prison.[36]

2.2.1. The European Prison Rules and health care in prisons and other places of detention

Another relevant recommendation by the Council of Europe is the European Prison Rules (hereafter: EPR), revised in 2006.[37] As with other recommendations, the EPR are not legally binding. Still, their adoption in 1987 and marked a significant development in the emergence of European prison policy formulating a specifically European approach in that they contain a list of basic principles that underline their fundamental commitment to ensuring the human dignity of all prisoners.[38]

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35 OHCHR 2005, p. V.

36 Recommendation of the Committee of Ministers Concerning the Ethical and Organisational Aspects of Health Care in Prison, No. R (98) 7, and the Recommendation of the Committee of Ministers of the Council of Europe, concerning Prison and Criminological Aspects of the Control of Transmissible Diseases including AIDS and Related Health Problems in Prison, No. R (93)6.

37 Council of Europe, European Prison Rules, Recommendation R (2006)2, adopted by the Committee of Ministers on 11 January 2006.

38 Van Zyl Smit & Snacken 2008, p. 23.

Currently, the EPR are used as a source of inspiration for the ECtHR and the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. In Rule 39 of the EPR it is determined that "Prison authorities shall safeguard the health of all prisoners in their care". According to Rule 10.1 of the EPR, the Rules apply to persons "who have been remanded in custody by a judicial authority or who have been deprived of their liberty following conviction".[39] Rule 10.2 determines that these persons "should only be detained in prisons, that is, in institutions reserved for detainees of these two categories". Accordingly, the terms prison and prisoner are used in the same sense as in this study. Nevertheless, pursuant to Rule 10.3 under A and B, the EPR are also applicable to a) persons who are detained for any reason in a prison, and b) persons who have been remanded in custody by a judicial authority or deprived of their liberty following conviction and who may, for any reason, be detained elsewhere. These groups are also considered as prisoners for the purposes of the EPR (paragraph 3); in this study, however, these two groups are referred to as detainees. A further group should be mentioned – asylum seekers who are deprived of their liberty in a special centre, not a prison. This category of persons in custody does not fall under the protection of the EPR. When dealing with the EPR, I will use the terms and definitions as used in the document itself. In Part III of the EPR, provisions concerning the health and welfare of prisoners are set out. In this part detailed rules are formulated on how prison health care services are to be arranged. The first Rule mentioned in this part determines that "[p]rison authorities shall safeguard the health of all prisoners in their care." Accordingly, it is a task for the prison authorities to provide prisoners with adequate medical care. In line with previously mentioned international documents and standards on equivalence of care, the EPR also emphasise the fact that prisoners must have access to the health services available in the country without discrimination on the grounds of their legal situation (Rule 40.3).

2.2.2. Positive obligations under Article 3 ECHR and health care in prisons and other places of detention

For the development of standards for the treatment of prisoners and detainees in general, and health care in prisons and other places of detention in particular, case law of the ECtHR has proved to be very important. Besides complaints on material custodial conditions, the question of adequate medical care in prison has been the object of many cases before the ECtHR. In most of these cases, Article 3 ECHR is invoked. Article 3 contains the prohibition of torture and inhuman or degrading

[39] For juvenile offenders subject to sanctions or measures, special rules have been created: Recommendation of the Committee of Ministers on the European Rules for juvenile offenders subject to sanctions or measures, No. R. (2006)2. Adopted by the Committee of Ministers on 5 November 2008 at the 1040th meeting of the Ministers' Deputies.

treatment or punishment and reads as follows: "No one shall be subjected to torture or to inhuman or degrading treatment or punishment." A similar provision can be found in Article 7 of the ICCPR. Article 3 ECHR and Article 7 ICCPR prohibit serious breaches of the right to physical integrity. Although Article 3 ECHR was not specifically designed to govern situations in prisons or other places of detention, nor situations in which health care is provided, it has, *inter alia*, been used in cases before the ECtHR to judge custodial circumstances, and cases in which (mostly forced) medical treatment was provided (see § 6.2.2.4 of this chapter). Article 3 ECHR is absolute: it does not provide an exclusion clause by which inhuman or degrading treatment or punishment can be justified.

Article 3 not only imposes negative obligations (to refrain from acts that constitute ill-treatment), but also contains positive obligations for States to provide adequate medical care to persons who are deprived of their liberty. In several cases, the ECtHR has declared that "[Article 3] imposes an obligation on the State to protect the physical well-being of persons deprived of their liberty, for example by providing them with the requisite medical assistance".[40] The Grand Chamber of the ECtHR ruled in the 2000 case of *Kudla* that this positive obligation obliges States to ensure

> "that a person is detained in conditions which are compatible with respect for his human dignity, that the manner and method of the execution of the measure do not subject him to distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in detention and that, given the practical demands of imprisonment, his health and well-being are adequately secured by, among other things, providing him with the requisite medical assistance."[41]

In subsequent cases, the ECtHR has added that not only unsatisfactory conditions of detention such as overcrowding and unsatisfactory conditions of hygiene and sanitation, but also inadequate medical care can amount to degrading treatment as prohibited under Article 3 ECHR.[42] Medical care must not only be provided to protect prisoners and detainees against ill-treatment (in preventing mental and physical suffering) as safeguarded under Article 3, but it must also protect prisoners' and detainees' physical and mental integrity, as safeguarded under Article 8 ECHR (see § 6.2.2.5 of this chapter). Article 3 ECHR does not oblige States to release prisoners and detainees on health grounds or to transfer them to regular hospitals, even if they are suffering from an illness that is particularly difficult to treat.[43] In exceptional cases,

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40 ECtHR 14 November 2002, *Mouisel v France*, App. No. 67263/01. Also: ECtHR 28 January 1994, *Hurtado v Switzerland*, App. No. 17549/90, and ECtHR 15 January 2004, *Matencio v France*, App. No. 58749/00.

41 ECtHR 26 October 2000, *Kudla v Poland,* App. No. 30210/96 (Grand Chamber), paragraph 94.

42 ECtHR 28 March 2006, *Melnik v Ukraine,* App. No. 72286/01, paragraph 111.

43 ECtHR 14 November 2002, *Mouisel v France*, App. No. 67263/01, paragraph 50.

however, where the state of a detainee's health is wholly incompatible with detention, Article 3 may require his release under certain conditions. Accordingly, Article 3 cannot be construed as laying down a general obligation to release detainees on health grounds. It rather imposes an obligation on the State to protect the physical well-being of persons deprived of their liberty.

Although the ECtHR acknowledges that prison hospitals may not always be to the same standard as offered by the best medical institutions for the general public, the State must ensure that the health and well-being of detainees are adequately secured.[44] The requirement to provide prisoners and detainees with medical care not only includes treatment of prisoners' sickness, but also requires adequate dental care, which may include the prisoner being provided with a set of dentures,[45] it also demands special care and treatment of persons suffering from mental disorders,[46] of disabled persons,[47] of the elderly,[48] and of drug addicts suffering from withdrawal symptoms.[49] This broad interpretation of "health" is in accordance with the definition of health by the WHO, which defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[50]

It can be concluded that, although the ECHR does not include stipulations concerning health care or concerning health care in prisons or other places of detention (in contrast to the ICCPR, for example), the ECtHR has developed concrete standards for prisoners' and detainees' health care in its case law concerning violations of Article 3 ECHR. In § 5 of this chapter, I will elaborate on the State's positive obligations to safeguard the life of prisoners and detainees on the basis of Article 2 ECHR. As will be demonstrated there, similarities exist in the development of positive obligations under Articles 2 and 3 ECHR concerning the duty to provide adequate medical care to prisoners and detainees. When, in case of death of a prisoner or detainee as a result of the lack of adequate medical care, the ECtHR concludes that Article 2 ECHR has been violated, as the lack of medical assistance contributed in a decisive manner to the fatal outcome of the case, the ECtHR can deem it unnecessary to make a separate finding under Article 3 ECHR, having already dealt with the matter under Article 2 ECHR.[51]

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44 ECtHR 23 February 2010, *Dermanović v Serbia*, App. No. 48497/06, paragraph 52, with references.

45 ECtHR 16 February 2010, *V.D. v Romania,* App. No. 7078/02.

46 ECtHR 26 October 2000, *Kudla v Poland,* App. No. 30210/96 (Grand Chamber).

47 ECtHR 10 July 2001, *Price v United Kingdom,* App. No. 33394/96.

48 ECtHR 2 December 2004, *Farbtuhs v Latvia,* App. No. 4672/02.

49 ECtHR 29 April 2003, *McGlinchey v United Kingdom,* App. No. 50390/99.

50 Constitution of the WHO. Adopted by the International Health Conference held in New York 19-22 July 1946; entry into force on 7 April 1948. Text available at <http://www.who.int/governance/eb/who_constitution_en.pdf> (last accessed on 16 January 2012).

51 See, for example, ECtHR 13 June 2002, *Anguelova v Bulgaria*, App. No. 38361/97, paragraphs 125-131 and 147-150.

2.2.3. Equivalence of care

In § 2.1.2 of this chapter, I discussed the equivalence of care principle as codified in international standards. As shown there, this principle is a guiding principle in UN documents on health in prisons, and its importance is highlighted by the WHO and WMA. Although the CPT has strongly proclaimed the principle of equivalence of health care in prisons with that in the outside community several times,[52] the ECtHR does not always adhere to this standard, at least when it comes to medical assistance for convicted prisoners (as opposed to those detained on remand).[53] From 2007, in cases against Russia and the Ukraine concerning prisoner's complaints about the lack of medical treatment in prison, the ECtHR has held on several occasions that, although the health of prisoners has to be adequately secured, "Article 3 of the Convention cannot be interpreted as securing to every detained person medical assistance of the same level as 'in the best civilian clinics'." The ECtHR is furthermore "prepared to accept that in principle the resources of medical facilities within the penal system are limited compared to those of civil[ian] clinics". On the whole, the ECtHR reserves flexibility in defining the required standard of health care, deciding it on a case-by-case basis. That standard should be "compatible with the human dignity" of a detainee, but should also take into account "the practical demands of imprisonment".[54] Besides this, Article 3 ECHR cannot be interpreted as requiring a prisoner's or detainee's every wish and preference regarding medical treatment to be accommodated. The ECtHR acknowledges that in this matter, the

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52 See CPT *3rd General Report* [CPT/Inf (93) 12], paragraphs 38-44. Also in the Recommendation of Ministers Concerning the Ethical and Organisational Aspects of Health Care in Prison, No. R (98) 7, the equivalence of care principle is proclaimed, stating that "the respect for the fundamental rights of prisoners entails the provision to prisoners of preventive treatment and health care equivalent to those provided to the community in general".

53 Still, the ECtHR has upheld the principle of equivalence of care as promulgated by the CPT in several cases. In 2008, for example, the ECtHR noted in the case of *Shelly* that "[i]n this case the applicant complains of different standards of health care being applied in prison. The Court would observe that the [CPT] and the domestic prison regulations themselves provide that the health care in prisons should be the same as that in the community. For the purposes of the present application, therefore, the Court is prepared to assume that prisoners can claim to be on the same footing as the community as regards the provision of health care." Here, the ECtHR referred to the case of *Mathew* where it had already stated that "[t]he treatment of prisoners in ordinary hospitals rather than in prison ensures that medical facilities and staff remain available to provide health care outside prison; it also offers prisoners access to medical assistance of the same standard as that provided to the general public." ECtHR 4 January 2008, *Shelley v the UK,* App. No. 23800/06 (decision on admissibility) and ECtHR 29 September 2005, *Mathew v the Netherlands*, App. No. 24919/03, par. 193.

54 ECtHR 22 December 2008, *Aleksanyan v Russia*, App. No. 46468/06, paragraphs 139-140 and ECtHR 15 November 2007, *Grishin v Russia*, App. No. 30983/02, paragraphs 72-76. Reiterated in ECtHR 15 October 2009, *Okhrimenko v Ukraine*, App. No. 53896/07, paragraph 69.

practical demands of legitimate detention may impose restrictions that a prisoner will have to accept.[55]

2.2.4. CPT and health care in prisons and other places of detention

Article 3 ECHR not only stimulated the creation of prison health care standards in the case law of the ECtHR, it also inspired the drafting of the 1987 European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (hereafter: ECPT). Currently, the ECPT has been ratified by all the 47 Member States of the Council of Europe. Article 1 of the ECPT establishes the CPT: "The Committee shall, by means of visits, examine the treatment of persons deprived of their liberty with a view to strengthening, if necessary, the protection of such persons from torture and from inhuman or degrading treatment or punishment." The work of the CPT is designed to be an integrated part of the Council of Europe system for the protection of human rights of prisoners and detainees. It places a proactive non-judicial mechanism alongside the existing reactive judicial mechanism of the ECtHR. In other words, the CPT is intended to complement the bodies set up under the ECHR.[56] Article 17 of the Explanatory Report on the ECPT emphasises that the CPT must not perform any judicial functions and must refrain from interpreting the ECHR:

> "It is not for the committee to perform any judicial functions; it is not its task to adjudge that violations of the relevant international instruments have been committed. Accordingly, the committee shall also refrain from expressing its views on the interpretation of those instruments either in *abstracto* or in relation to concrete facts."

The aim of the CPT is to prevent torture and inhuman or degrading treatment or punishment from occurring. The CPT exercises this essential preventive function through its periodic follow-up and ad hoc visits. Periodic visits to a country take place every four or five years. The aim of follow-up visits is to ascertain that recorded shortcomings have been redressed. Ad hoc visits can be organised if they appear "to be required in the circumstances" i.e., if there is a strong suspicion exists that persons who have been deprived of their liberty are being ill-treated.[57] Visits may be carried out at any place "where persons are deprived of their liberty by a public authority", such as prisons or other places of detention. The CPT's mandate thus extends beyond prisons and police stations to encompass, for example, psychiatric institutions, detention areas at military barracks, holding centres for asylum seekers

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55 ECtHR 29 September 2005, *Mathew v the Netherlands,* App. No. 24919/03, paragraphs 186 and 187.

56 Myjer 2010, p. 163, with references.

57 Van Kalmthout & Leidekker 2009, p. 758.

or other categories of foreigners, and places in which young persons are deprived of their liberty by judicial or administrative order.[58] (This covers a wide group of people who are deprived of their liberty, who I refer to as prisoners and detainees.) During visits, the CPT enjoys extensive powers, such as unlimited access to any place where persons are deprived of their liberty and the right to move inside such places without restriction. The CPT may also interview persons who are deprived of their liberty in private and communicate freely with anyone who can provide information. The CPT also has access to any information necessary for it to carry out its mandate. In this way, the CPT is able to fully carry out its task. After a visit, a report of the CPT's findings and recommendations is drawn up and sent to the Member State concerned in order to launch a dialogue. In principle, the CPT reports are confidential, but most States elect to publish them.[59] The CPT reports, both the visit reports as the General Reports, provide detailed information on how persons deprived of their liberty should be treated.

In addition, the CPT has developed the CPT Standards (hereafter: Standards) for some of the substantive issues which it pursues when carrying out visits. In this way, it seeks to provide States with clear guidelines on how persons who are deprived of their liberty ought to be treated and, more generally, to stimulate discussion on such matters.[60] Even though the CPT Standards and reports are not binding on States, the CPT has established itself as a significant player in creating standards and safeguards for the humane treatment of prisoners and detainees. Since its inception, the CPT has played an important role in the development of standards for the humane treatment of persons who are deprived of their liberty. The Standards the CPT has developed and applied are now arguably of greater practical significance than the EPR, to which the CPT seldom makes reference. In its Standards and reports, the CPT has developed for itself standards and safeguards for prisons and other places of detention in a more detailed manner than any other European instrument to be able monitor conditions in prisons and other places of detention more objectively.[61] Case law shows that the ECtHR increasingly refers to CPT reports and Standards in its rulings, and uses them to decide in concrete

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58 The CPT Standards. "Substantive" sections of the CPT's General Reports, Council of Europe, CPT/Inf/E (2002) 1 – Rev. 2010. Available at <http://www.cpt.coe.int/EN/docsstandards.htm> (last accessed on 16 January 2012), p. 5.

59 <http://cpt.coe.int/en/about.htm> (last accessed on 25 January 2012) and "Preface" of the CPT Standards.

60 The CPT Standards. "Substantive" sections of the CPT's General Reports, Council of Europe, CPT/Inf/E (2002) 1 – Rev. 2010. Available at <http://www.cpt.coe.int/EN/docsstandards.htm> (last accessed on 16 January 2012). The full text of the CPT Standards, as well as all the published reports on CPT visits to States Parties, together with the responses of the authorities concerned, can be accessed on the CPT's website.

61 Morgan 2001, p. 717; Murdoch 2006, p. 45.

cases.[62] The CPT norms in particular form an important source in deciding on custodial conditions and circumstances. The CPT is often called a "fact finder" for the ECtHR. Besides this fact-finding task, the CPT has increasingly become a creator in new penal law and policy, as CPT norms more often are applied in individual cases before, especially in cases in which the ECtHR is confronted with aspects of detention over which the ECtHR has not previously ruled.[63]

As stated earlier, adequate health care services are very important for the prevention of ill-treatment in prisons and other places of detention. In its third General Report the CPT stated

> "Health care services for persons deprived of their liberty is a subject of direct relevance to the CPT's mandate. An inadequate level of health care can lead rapidly to situations falling within the scope of the term "inhuman and degrading treatment". Further, the health care service in a given establishment can potentially play an important role in combatting the infliction of ill-treatment, both in that establishment and elsewhere (in particular in police establishments). Moreover, it is well placed to make a positive impact on the overall quality of life in the establishment within which it operates."[64]

Aiming to protect prisoners and detainees against torture and inhuman or degrading treatment, the CPT has devoted itself to a wide range of issues, including health care in prisons and other places of detention, and the medical treatment of prisoners and detainees. There is no surprise here, given the CPT's composition. Unlike for example the ECtHR, the CPT consists of not only legal experts. In January 2012, the CPT consisted of 22 lawyers, seven medical doctors and five psychiatrists, two who are both lawyer and medical doctor, and eight from other professional groups.[65] The third "substantive section" of the Standards is entirely devoted to the issue of health care services in prison, and the CPT has dedicated several General Reports to it.[66] In its Standards, the CPT consistently refers to patients instead of

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62 Djurdjevic 2009, p. 74ff and Hagens 2011, p. 229ff.

63 De Lange 2008, p. 183ff. On the relationship between the ECtHR and the CPT and their contribution to an effective and efficient protection of prisoners and detainees against torture and inhuman or degrading treatment or punishment, see Hagens 2011.

64 *3rd General Report,* CPT/Inf (93) 12, paragraph 30.

65 For an overview of the CPT's members, see <http://www.cpt.coe.int/en/members.htm> (last accessed on 16 January 2012). Each of the 47 States that have ratified the ECPT has one member in the CPT. The CPT currently consists of 44 members, as the seats of the following three States are vacant: Bosnia and Herzegovina, Moldova and Spain.

66 The CPT has elaborated on the topic of health care in prison in, *inter alia*, its *3rd General Report,* CPT/Inf(93) 12, paragraphs 30-77, that contains general remarks on health care in prison. The CPT has also dedicated parts of reports to health care for specific categories of prisoners, such as women (CPT *10th General Report,* CPT/Inf(2000) 13, paragraphs 30-33) and juveniles (CPT *9th General Report*, CPT/Inf(99) 12, paragraphs 37-41).

prisoners or detainees to emphasise that a prisoner or detainee who needs medical care should be treated as any other patient.

3. DUAL LOYALTIES

A prison physician (but also other health care providers in prisons or other places of detention) can be faced with dual loyalties: he provides prisoners with daily medical care, is a house doctor to them, and has a relationship with them that is based on trust. At the same time, however, he plays an important role in advising the prison board on, for example, the medical fitness of prisoners for work and sports and the performance of medical treatment against the prisoner's wishes. Also, the prison physician plays a crucial role in general health matters and crisis situations, in the latter of which his judgment is often decisive, such as with the placement of a (sometimes fixated) prisoner in an isolation cell. In practice, problems often arise when prison physicians are asked by the prison governor or the custodial board to execute invasive medical examinations (for example internal examination of the prisoner's body) or compulsory treatment of prisoners, such as force-feeding of a prisoner or detainee on hunger strike. On the basis of his relationship of trust with his patients, the physician may be opposed to the undertaking of such treatment. Such dilemmas are most intense when the physician is employed by the prison or the Ministry of Justice. International instruments, such as the CPT[67] and the UN Principles of Medical Ethics have gone into the issue of dual loyalties of health care providers in custodial settings. As the issue of dual loyalties is a delicate issue in force-feeding of prisoners and detainees, the WMA has elaborated on their guiding document on hunger strikes, the Declaration of Malta, upon which I will elaborate in Ch. 5, § 2.2.2.

4. HUMAN RIGHTS FOR PRISONERS AND DETAINEES OR "INHERENT LIMITATIONS"?

Prisoners and detainees are deprived of one of their most fundamental and basic rights: the right to liberty. Although the situation of deprivation of liberty often hampers the enjoyment of human rights, these rights are applicable to prisoners and detainees, in the same way as they are to all other people. This is in line with the general thought behind human rights: they derive from the inherent dignity of the human person. Several international human rights instruments implicitly or explicitly express the relevance of human rights for prisoners and detainees.

[67] See, for example, the CPT's *3rd General Report,* CPT/Inf (93) 12, paragraphs 71-74 under "Professional independence".

Article 10 ICCPR states that "[a]ll persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person". In my view, this respect is one of the most fundamental and basic values in human rights instruments. By applying this standard to both prisoners and detainees, the ICCPR demands equal respect for their rights as for people who are free. In a General Comment, the Human Rights Committee noted that Article 10, paragraph 1, ICCPR imposes a "positive obligation" to protect the human rights (*inter alia*, the right to be protected from torture as illustrated in Article 7 ICCPR) of the vulnerable group of persons who are deprived of their liberty.

> "Thus, not only may persons deprived of their liberty not be subjected to treatment that is contrary to article 7, including medical or scientific experimentation, but neither may they be subjected to any hardship or constraint other than that resulting from the deprivation of liberty; respect for the dignity of such persons must be guaranteed under the same conditions as for that of free persons. Persons deprived of their liberty enjoy all the rights set forth in the Covenant, subject to the restrictions that are unavoidable in a closed environment."[68]

Accordingly, in Principle 5 of the UN Basic Principles for the Treatment of Prisoners, it is explicitly stated that

> "[e]xcept for those limitations that are demonstrably necessitated by the fact of incarceration, all prisoners shall retain the human rights and fundamental freedoms set out in the Universal Declaration of Human Rights, and, where the State concerned is a party, the International Covenant on Economic, Social and Cultural Rights, and the International Covenant on Civil and Political Rights and the Optional Protocol thereto, as well as such other rights as are set out in other United Nations covenants."

From this it may be concluded that, according to the Human Rights Committee and the Basic Principles for the Treatment of Prisoners, the human rights of persons who are deprived of their liberty may not be restricted more than is inherent to their deprivation of liberty. This is in line with the thought that human rights are certain rights and freedoms that are essential to human existence and apply to every human being, even when they are deprived of their liberty. This is also underlined by Penal Reform International, that states that "[r]egardless of circumstances, all human beings have fundamental human rights. They cannot be taken away without legal justification. People held in lawful detention or in prison forfeit for a time the right to liberty. If they are in unlawful detention or imprisonment, they retain all rights including the right to liberty." Still, it is acknowledged that some rights may be

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[68] General Comment No. 21 concerning humane treatment of persons deprived of their liberty, 10 April 1992, paragraph 5.

limited by the fact of detention or imprisonment. "These [rights] include: the right to certain personal liberties; the right to privacy; freedom of movement; freedom of expression; freedom to assembly and freedom to vote. The important issue is whether and to what extent and further limitation of human rights is a necessary and justifiable consequence of deprivation of liberty."[69] Some argue that because prisoners and detainees are deprived of their liberty and because they are dependent on the State, the extent of their human rights is more restricted by definition than would be the case with citizens who are at liberty. In this view, deprivation of freedom would inherently entail loss of other rights and freedoms (such as the right to be protected from torture or to inhuman or degrading treatment or punishment). This doctrine is that of the "inherent (or implied) limitations".

For a long time, the doctrine of inherent limitations (particularly used in cases on the right to correspondence pursuant to Article 8 ECHR) was the standard used in Strasbourg.[70] In many cases, the EComHR declared that, as long as the deprivation of freedom itself was in accordance with Article 5 ECHR, such restrictions did not fall within the scope of the exception clause of the Article itself, but were inherent features of the punishment of imprisonment. In 1966 the EComHR ruled that "the limitation of the right of a detained person to conduct correspondence is a necessary part of his deprivation of liberty which is inherent in the punishment of imprisonment".[71] In case law after 1967, the EComHR no longer referred to restrictions laid down in the articles themselves, but only declared that restrictions on certain human rights are inherent to the concept of detention, and not only applied this doctrine to the right to correspondence, but also to the prisoner's right to private life (under Article 8 ECHR), right to religion (under Article 9 ECHR), and right to information (under Article 10 ECHR), all of which contain express limitation clauses. Restrictions on these rights were considered to be inherent to the situation of deprivation of liberty and needed no further justification.[72]

In the 1970s, the ECtHR abolished the doctrine of the inherent limitations in the *Vagrancy* and *Golder* cases.[73] In the latter case, the ECtHR acknowledged for the first time that States' restrictions on a prisoner's right to contact a solicitor should be adequately justified, and stated that the concept of inherent limitations conflicts with the explicit text of Article 8 ECHR. In the words of the ECtHR:

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69 Penal Reform International 2001, pp. 5-6.

70 The theory of inherent limitations was first applied in 1965 and 1966, in EComHR 15 December 1965, X v Federal Republic of Germany, Collection of Decisions of the European Commission of Human Rights 18, 47 and EComHR 23 May 1966, X v Austria, Collection of Decisions of the European Commission of Human Rights 20, 1.

71 EComHR 11 July 1967, *Kenneth Hugh de Courcy v United Kingdom.*

72 Smaers 1994, pp. 21-23, with references.

73 ECtHR 18 June 1971, *De Wilde, Ooms and Versyp v Belgium (Vagrancy case),* App. No. 2832/66; 2835/66; 2899/66 and ECtHR 21 February 1975, *Golder v United Kingdom,* App. No. 4451/70.

"The restrictive formulation used at paragraph 2 ('There shall be no interference … except such as …') leaves no room for the concept of implied limitations."[74] The possibility to restrict the rights as contained in Article 8 ECHR are thus not susceptible to limitations other than those that are exhaustively enumerated in the second paragraph of the Article. According to the ECtHR the fact that a prisoner is detained, however, remained a factor in deciding whether the interference was "necessary": "the 'necessity' for interference with the exercise of the right of a convicted prisoner […] must be appreciated having regard to the ordinary and reasonable requirements of imprisonment."[75] In this way, the ECtHR leaves room for the "prevention of disorder or crime", for example, to justify wider measures of interference with persons who are deprived of their liberty than of persons at liberty.

The *Golder* case meant an important step towards the recognition that prisoners' and detainees' rights can only be restricted on the same basis as the rights of all other persons to whom the ECHR applies. The rights of persons who are deprived of their liberty are not subjected to inherent limitations, but can only be restrained on the general grounds laid down in the ECHR itself. However, after ruling on these two cases, it still took a long time before the ECtHR completely changed its policy; before the ECtHR, absolute rights (such as Article 3 ECHR) were still interpreted strictly, while non-absolute rights (such as Article 8 ECHR) restrictions were interpreted widely. Only in the last 15 years has the ECtHR systematically established violations in cases brought before it by prisoners and detainees.[76]

Nowadays, it is recognised that persons who are deprived of their liberty are entitled to all the rights and freedoms laid down in the ECHR. In the 2005 *Hirst* case, the Grand Chamber of the ECtHR stated explicitly, in considering the legitimate aim of United Kingdom legislation that prohibited convicted prisoners to vote, that

> "[p]risoners in general continue to enjoy all the fundamental rights and freedoms guaranteed under the Convention save for the right of liberty, where lawfully imposed detention expressly falls within the scope of Article 5 of the Convention. For example, prisoners may not be ill-treated, subjected to inhuman or degrading punishment or conditions contrary to Article 3 of the Convention […], they continue to enjoy the right to respect for family life […] the right to freedom of expression […]."[77]

Here, the ECtHR again gives voice to the idea that prisoners continue to enjoy all the rights as laid down in the ECHR, including the absolute prohibition of torture,

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74 ECtHR 21 February 1975, *Golder v United Kingdom,* App. No. 4451/70, paragraph 44.

75 Ibid., paragraph 45.

76 Smaers 1994, pp. 34-37, and Smaers 2005, p. 4.

77 ECtHR 6 October 2005, *Hirst v the United Kingdom (No. 2)* (Grand Chamber*),* App. No. 74025/01, paragraph 69.

inhuman or degrading punishment or treatment as laid down in Article 3 ECHR. Restrictions on other (non-absolute) rights, such as the right to respect for private and family life, the right to freedom of expression, the right of effective access to a lawyer or to a court for the purposes of Article 6, the right of correspondence, and the right to marry must be adequately justified. As in the *Golder* case, the ECtHR acknowledges that such justification for those deprived of their liberty may be found in the considerations of security, in particular the prevention of crime and disorder, which inevitable follows from the circumstances of imprisonment. Such considerations may entail that, for example, the right to correspondence is restricted by stopping specific letters containing threats or other objectionable references.[78] In 2007, in the case of *Dickson*, a case concerning the refusal to provide artificial insemination facilities in prison, the Grand Chamber of the ECtHR reiterated its conclusions from the *Hirst* case and added that

> "Accordingly, a person retains his or her Convention rights on imprisonment, so that any restriction on those rights must be justified in each individual case. This justification can flow, inter alia, from the necessary and inevitable consequences of imprisonment […] or […] from an adequate link between the restriction and the circumstances of the prisoner in question. However, it cannot be based solely on what would offend public opinion."[79]

In dealing with the alleged violation of Article 8, the ECtHR furthermore noted that, although the object of Article 8 is essentially that of a negative obligation (to protect the individual against arbitrary interference by the public authorities) it may also bring along positive obligations that may involve the adoption of measures design to secure respect for private and family life.[80] This line of reasoning may also demand States to not only respect prisoners' and detainees' human rights, but also facilitate its exercise.

It may be concluded that the doctrine of the "justified limitations", as first illustrated in the *Golder* case, is nowadays still the generally accepted standard.[81]

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78 ECtHR 6 October 2005, *Hirst v the United Kingdom* (Grand Chamber), App. No. 74025/01, paragraph 69, referring to ECtHR 25 March 1983, *Silver and others v the United Kingdom*, Publications of the European Court of Human Rights: Judgments and Decisions, Series A No. 61, App. No. 5947/72; 6205/73; 7052/75; 7061/75; 7107/75; 7113/75; 7136/75. In this case, the ECtHR ruled that the stopping of specific letters containing threats or other objectionable references was justifiable in the interests of the prevention of disorder or crime.

79 ECtHR 4 December 2007, *Dickson v the United Kingdom,* App. No. 44362/04 (Grand Chamber), paragraph 68.

80 Ibid., paragraph 70.

81 This doctrine is illustrated by the case law of the ECtHR in which it has developed quite stringent standards as regards the confidentiality of prisoners' legal and medical correspondence. See ECtHR 22 May 2008, *Petrov v Bulgaria*, App. No. 15197/02, paragraph 43 and ECtHR 2 June 2009, *Szuluk v the United Kingdom,* App. No. 36936/05, paragraphs 46-55.

The EPR embody the doctrine of the "justified limitations" as developed by the ECtHR in formulating the basic principle that "persons deprived of their liberty retain all rights that are not lawfully taken away by the decision sentencing them or remanding them in custody" and emphasising (under 102.2) that "imprisonment is by the deprivation of liberty a punishment in itself and therefore the regime for sentenced prisoners shall not aggravate the suffering inherent in imprisonment". In its commentary to the second basic principle, the Council of Europe elaborated on this by emphasising that "the undoubted loss of the right to liberty that prisoners suffer should not lead to the assumption that prisoners automatically lose their political, civil, social, economic and cultural rights as well. Inevitably rights of prisoners are restricted by their loss of liberty but such further restrictions should be as few as possible."[82] Prisoners and detainees thus enjoy the same human rights as other citizens, save the right to liberty. Van Zyl Smit and Snacken note in this respect that even "[i]f the sentence of imprisonment was imposed for reasons of retribution, this does not in any way imply that the implementation of the sentence must lead to a prison regime that entails more punitiveness than the deprivation of the liberty of movement".[83] It can be concluded that being deprived of liberty is the punishment; conditions of imprisonment should not constitute additional punishment.

It can be concluded that prisoners and detainees continue to enjoy all the fundamental rights and freedoms guaranteed under the ECHR. A positive obligation rests on the custodial authorities to actually protect these human rights. But how far do these positive obligations go? Below, I will investigate the issue of positive obligations to safeguard the prisoner's and detainee's life under Article 2 ECHR, which is most often advanced in order to justify force-feeding in hunger strikes.

5. POSITIVE OBLIGATIONS ON THE BASIS OF ARTICLE 2 ECHR

From a European perspective, the State's duty to preserve the life of those who it has deprived of their liberty is founded on Article 2 ECHR. Article 2 ECHR safeguards the right to life and reads as follows.

> 1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.

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82 Commentary to Recommendation Rec(2006) 2 of the Committee of Ministers to Member States on the European Prison Rules, <http://www.coe.int/t/dghl/standardsetting/cdpc/E%20commentary%20to%20the%20EPR.pdf> (last accessed on 16 January 2012).

83 Van Zyl Smit & Snacken 2008, p. 81.

> 2. Deprivation of life shall not be regarded as inflicted in contravention of this article when it results from the use of force which is no more than absolutely necessary:
>
> a) in defence of any person from unlawful violence;
>
> b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;
>
> c) in action lawfully taken for the purpose of quelling a riot or insurrection.

On the basis of this Article, States are obliged to take measures to protect the life of their citizens. Article 2 is mostly invoked when issues of life and death are concerned. In case law, the ECtHR has reiterated that Article 2, which safeguards the right to life, ranks as one of the most fundamental provisions in the ECHR, from which no derogation is permitted:

> "Together with Article 3, it enshrines one of the basic values of the democratic societies making up the Council of Europe. The circumstances in which deprivation of life may be justified must therefore be strictly construed. The object and purpose of the Convention as an instrument for the protection of individual human beings requires that Article 2 has to be interpreted and applied so as to make its safeguards practical and effective."[84]

On the basis of Article 2, States must not only refrain from the intentional and unlawful taking of life, but must also take appropriate steps to safeguard the lives of those within their jurisdiction.[85] This, *inter alia*, involves a duty to secure the right to life by putting in place effective criminal law provisions to deter the commission of offences against the person backed up by law-enforcement machinery for the prevention, suppression and punishment of breaches of such provisions. In certain circumstances, this duty extends to a positive obligation on the authorities to take preventive operational measures to protect an individual whose life is at risk from the criminal acts of another individual. The scope of this positive obligation must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities.[86]

Like Article 3 ECHR, Article 2 was not specifically written for prisoners and detainees. Article 2, however, plays an important role in discussions on the protec-

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84 ECtHR 27 September 1995, *McCann and Others v the United Kingdom,* App. No. 18984/91 (Grand Chamber), paragraphs 146 and 147, ECtHR 5 July 2005, *Trubnikov v Russia*, App. No. 49790/99, paragraph 67, and ECtHR 27 June 2000, *Salman v Turkey* (Grand Chamber), App. No. 21986/93, paragraph 97.

85 ECtHR 9 June 1998, *L.C.B. v the United Kingdom*, App. No. 23413/94, paragraph 36.

86 ECtHR 3 April 2001, *Keenan v the United Kingdom,* App. No. 27229/95, paragraphs 89 and 90, referring to ECtHR 28 October 1998, *Osman v the United Kingdom* (Grand Chamber), App. No. 23452/94, paragraphs 115 and 116.

tion of life and the prevention of the infliction of death in custody. As we have seen in Ch. 3, § 4, prisoners and detainees retain all rights except the right to liberty. However, as Van Kempen rightfully notes, deprivation of liberty to a large extent complicates, restricts or even removes the possibility that individuals can assert their human rights. In his opinion this certainly does not mean that a person in detention legally forfeits all his rights merely because of his status as a prisoner. He argues that

> "[h]uman rights law is even more complicated in respect of prisoners than it already is in relation to free individuals. Perhaps the real difficulty concerns not so much which human rights prisoners have, but which obligations rest on the authorities to ensure those rights. Where the assurance of a human right to a free individual only demands that the State does not breach the right (a negative duty), in case of a prisoner this will usually also require that the authorities actively shape the preconditions which the prisoner can actually enjoy the right (a positive duty). Thus, besides negative obligations – such as the obligation not to torture detainees – prison authorities have numerous positive obligations."[87]

Accordingly, the State and its authorities are under a positive obligation to actually secure those human rights in prisons and other places of detention. The creation of such positive obligations is inspired by the idea that the State has brought someone into a situation in which he cannot provide for himself as well as he generally would be able to if he was at liberty. As a result, authorities of prisons and other places of detention have a duty to actively compensate this state-imposed inability of the prisoner or detainee to take care of himself.[88]

Article 2 ECHR has played an important role in the formulation of positive obligations for States to protect the lives of those it has deprived of their liberty. The ECtHR has repeatedly acknowledged that the right to life is especially important in situations in which persons are deprived of their liberty, as these persons find themselves in a vulnerable position because they face a higher risk of their right to life being violated. In *Edwards*, the ECtHR stated that "[i]n the context of prisoners, the Court has had previous occasion to emphasise that persons in custody are in a vulnerable position and that the authorities are under a duty to protect them".[89] Adequate medical and physical treatment is not only very important in the prevention of torture and cruel and degrading treatment (as we have seen in § 2.2.2 of this chapter) but also in the protection of life and the prevention of death under Article 2.

The State and its authorities are under a duty to protect prisoners' and detainees' lives, but how far does this duty extend? Can positive obligations under Article 2

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87 Van Kempen 2008, p. 21.

88 Ibid., pp. 32 and 43.

89 ECtHR 14 March 2002, *Paul and Audrey Edwards v the United Kingdom,* App. No. 46477/99, paragraph 56.

oblige States to take measures to prevent a prisoner or detainee from taking his own life, even if this is his express wish? In the case of force-feeding, this could lead to the awkward situation that, however positive obligations are initially invoked to ensure the human rights of prisoners, they may also be used to justify a restriction of the prisoner's human rights. Before going into the case law of the ECtHR concerning this topic in Ch. 5, § 3.4, let us first explore the ECtHR case law that has dealt with the relevance of Article 2 for prisoners and detainees in cases where persons have died in custody.

In the case of *Salman*, the Grand Chamber of the ECtHR ruled that "[i]n the light of the importance of the protection afforded by Article 2, the Court must subject deprivations of life to the most careful scrutiny, taking into consideration not only the actions of State agents but also all the surrounding circumstances".[90] In the case of *Keenan*, the ECtHR elaborated on this issue, again focusing on persons who are deprived of their liberty, stating that it is incumbent upon States to account for any injuries suffered by persons whilst deprived of their liberty. This obligation is particularly stringent if that individual dies.[91] In such cases, the State is under an obligation to account for the prisoner's or detainee's treatment, and therefore must provide a plausible explanation of the events leading to his death.[92] As a result, if an individual is taken into police custody in good health but is found to be injured at the time of release, it is incumbent on the State to provide a plausible explanation of how those injuries were caused, failing which a clear issue arises under Article 3 of the Convention.[93] As with Article 3 cases (see § 6.2.2.1), in cases under Article 2 the burden of proof is on the authorities to provide a satisfactory and convincing explanation for the death of a prisoner whilst in police custody, especially if the events at issue lie wholly or in large part within the exclusive knowledge of the authorities.[94] As under Article 3, the ECtHR adopts the standard of proof "beyond reasonable doubt" in assessing evidence in cases under Article 2. Such proof may follow from the coexistence of sufficiently strong, clear and concordant interference or of similar unrebutted presumptions of fact.[95] There is also a "procedural" aspect to Article 2: if a prisoner dies in suspicious circumstances, there is an obligation on State authorities to carry out an "effective official investigation". Such an investigation must be ordered by the State authorities as a matter of course. This investigation must be held as soon as

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90 ECtHR 27 June 2000, *Salman v Turkey* (Grand Chamber), App. No. 21986/93, paragraph 99.

91 ECtHR 3 April 2001, *Keenan v the United Kingdom,* App. No. 27229/95, paragraph 91.

92 ECtHR 13 June 2002, *Anguelova v Bulgaria*, App. No. 38361/97, paragraph 110.

93 ECtHR 27 August 1992, *Tomasi v France,* App. No. 12850/87, paragraphs 108-111 and ECtHR 28 July 1999, *Selmouni v France* (Grand Chamber), App. No. 25803/94, paragraph 87.

94 ECtHR 27 June 2000, *Salman v Turkey* (Grand Chamber), App. No. 21986/93, paragraph 100.

95 Ibid.

the matter is brought to the attention of the authorities in order to establish the cause of death and to identify and punish any parties responsible.[96]

Positive obligations on the basis of Article 2 ECHR in procedures before the ECtHR are mostly invoked in cases concerning prisoners and detainees who either committed suicide or were killed by other fellow prisoners or detainees. The ECtHR has dealt with alleged breaches of Article 2 ECHR in about ten cases brought before it by relatives of prisoners and detainees alleging that the State had failed to protect the life of the prisoner or detainee involved. In these circumstances, the ECtHR applied a two-pronged analysis in determining whether a State failed in its positive obligation under Article 2. As part of this assessment, the ECtHR first ascertains whether the authorities knew or ought to have known that the individual concerned was at any real and immediate risk. Secondly, the ECtHR considers whether the authorities took all necessary operational measures that could reasonably be expected from them to prevent that risk from materialising.[97] I will not discuss the case law of the ECtHR that concerns the State's positive obligation to protect a person's life from third parties such as fellow prisoners and detainees, but only cases in which the State was under a positive obligation to protect the person from the risk that was posed *to himself*.

Investigating these cases is relevant in order to determine the scope of Article 2 in preventing prisoners and detainees from taking their own lives whilst being deprived of their liberty. As I already explained in Ch. 1, § 3, hunger strikers are not usually suicidal. In this respect, the group of persons who have committed suicide differ greatly from the group of hunger strikers. Despite this difference, the case law concerning suicide in prisons or other places of detention may provide insight into the scope of Article 2 and the question of what can and must be expected from States to prevent a prisoner or detainee choosing to die.

To this end, I will discuss two cases. The first is the above-mentioned case of *Keenan v the United Kingdom*. The applicant in this case was the mother of Mark Keenan who, at the age of 28, committed suicide whilst serving a sentence of four months' imprisonment at HM Prison Exeter. The applicant complained that the prison authorities, through their treatment of her son prior to his suicide, failed to protect his right to life contrary to Article 2 ECHR. More specifically, she complained "that the prison authorities placed her son in a segregated environment in circumstances that involved a significant deprivation of therapeutic care, while they knew he was subject to a real and immediate risk of self-harm". In dealing with this case, the ECtHR notes first of all that prison authorities must discharge their duties in a manner that is compatible with the rights and freedoms of the individual concerned. "There are general measures and precautions which will be available to

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96 ECtHR 27 July 2004, *Slimani v France,* App. No. 57671/00, paragraphs 27-50. Described by Murdoch 2006, pp. 133-134.

97 Van Dijk et al. 2006, p. 356.

diminish the opportunities for self-harm, without infringing on personal autonomy. Whether any more stringent measures are necessary in respect of a prisoner and whether it is reasonable to apply them will depend on the circumstances of the case."[98] The ECtHR furthermore examined whether Keenan posed a real and immediate risk of suicide and, if so, whether the authorities did all that could reasonably have been expected of them to minimise that risk. The ECtHR concluded that the prison authorities knew that Mark Keenan's mental state was such that he posed a potential risk to his own life. The question was accordingly "whether the prison authorities did all that could reasonably be expected of them, having regard to the nature of the risk posed by Keenan". The ECtHR concluded that, on the whole, the authorities responded in a reasonable way to his conduct, placing him in hospital care and under watch when he evinced suicidal tendencies. In this way, the State had fulfilled its positive obligation under Article 2, and no violation of this Article had taken place.[99]

The second case is that of *Renolde*, a case that was brought before the ECtHR by the sister of Joselito Renolde, who hanged himself whilst in pre-trial detention.[100] The applicant submitted a similar claim as in the *Keenan* case, i.e., that the government had failed to take appropriate steps to protect Renolde's life with regard to the information available at the time the events had occurred. On the basis of Article 2, the ECtHR investigated whether, given the circumstances of the case, the State did all that could have been required of it to prevent the applicant's brother's life from being avoidably put at risk. In this case, the ECtHR first reiterated that "Article 2 may imply in certain well-defined circumstances a positive obligation on the authorities to take preventive operational measures to protect an individual from another individual or, in particular circumstances, from himself". The ECtHR added, however, that this positive obligation "must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities, bearing in mind the difficulties involved in policing modern societies, the unpredictability of human conduct and the operational choices which must be made in terms of priorities and resources. Accordingly, not every claimed risk to life can entail a Convention requirement for the authorities to take operational measures to prevent that risk from materialising." Lastly, the Court reiterated that, in the case of mentally ill persons, regard must be had to their particular vulnerability. Unlike in the *Keenan* case, in *Renolde*, despite the prisoner's mental condition, there had been no discussion of whether the prisoner should be admitted to a psychiatric institution. In such a case, the authorities should at the very least have provided the prisoner with medical treatment that corresponded to the seriousness of his condition, according to the ECtHR. Unlike Keenan, who suffered from a mild psychosis, Renolde suffered

98 ECtHR 3 April 2001, *Keenan v the United Kingdom,* App. No. 27229/95, paragraphs 91 and 92.

99 Ibid., paragraphs 93-102.

100 ECtHR 16 October 2008, *Renolde v France*, App. No. 5608/05.

from acute psychotic disorders, a mental illness that entails especially high risks for persons suffering from them. Although it is not known what made Renolde commit suicide, the ECtHR concluded that, in the circumstances of the case, the lack of supervision of his daily taking of medication played a part in his death (the medicine was only handed to him and left at his disposal). Furthermore, Renolde had been given the most severe disciplinary penalty shortly before he committed suicide; forty-five days' detention in a punishment cell. According to the ECtHR, "[t]he vulnerability of mentally ill persons calls for special protection". This applies all the more where a prisoner suffering from severe disturbance is placed, as in the instant case, in solitary confinement or a punishment cell for a prolonged period, which will inevitably have an impact on his mental state, and where he had actually attempted to commit suicide shortly beforehand. In the light of all of this, the ECtHR concluded that the authorities in the instant case had failed to comply with their positive obligation to protect Renolde's right to life, and that there had been a violation of Article 2 ECHR.[101]

These two cases illustrate the important role of the State authorities in preventing prisoners or detainees, especially those who are mentally ill, from taking their own lives. If information indicates that a prisoner or detainee poses a real and immediate risk of suicide, State authorities have to take appropriate steps to protect his life. Article 2 then implies a positive obligation on the State authorities to take preventive measures to protect the prisoner or detainee from himself. In my opinion, prisoners and detainees should be closely monitored to assess the risk of suicide. This is a task of both medical and other staff working within the prison or other place of detention.

Despite these two cases, it remains difficult to draw general conclusions on what is to be expected from the State and its authorities in fulfilling their positive obligations in prisons and other places of detention. In 2002, the ECtHR ruled that a delay in the provision of medical assistance that contributed in a decisive manner to the death of a prisoner or detainee constitutes a violation of Article 2.[102] This is in line with the case law concerning Article 3 ECHR that I discussed in § 2.2.2 of this chapter: prisoners and detainees should be provided with adequate and timely health care, according to the ECtHR. The cases of *Keenan* and *Renolde* show that the authorities must take steps that can reasonably be expected from the State and its authorities to prevent the death of the prisoner or detainee involved, having regard to the information available at the time. Obligations under Article 2 ECHR extend to a duty to prevent self-inflicted deaths in prisons or other places of detention where authorities were on notice of a real and immediate risk to life. Like suicidal prisoners and detainees, hunger strikers pose a risk to their own lives. Usually, authorities know about a hunger strikes and are aware of the risks it poses to the

101 Ibid., paragraphs 80-110.

102 ECtHR 13 June 2002, *Anguelova v Bulgaria*, App. No. 38361/97, paragraphs 125-131.

hunger striker's life, especially if the hunger striker perseveres. Unlike mentally ill prisoners, hunger strikers are often competent persons who consciously decide to stop eating, so they do not pose a risk to themselves as a result of a mental illness.

Still, this case law underlines the fact that the State and its authorities are under a positive obligation to protect the persons that they have deprived of their liberty from themselves, and that they are obliged to take operational measures to enforce this positive obligation. For now, it suffices to conclude that, on the basis of the ECtHR case law as discussed above, and in § 2.2.2 in relation to Article 3, States are under a positive obligation to closely monitor hunger strikers' mental status and to provide them with adequate medical care. Whether, according to the ECtHR, this positive obligation also obliges States to intervene in a hunger strike through the use of force-feeding will be investigated in Ch. 5, § 3.4.

Like most of the arguments that can be put forward in favour of force-feeding (as will be shown in the next chapter), the duty to protect a prisoner's and detainee's right to life on the basis of Article 2 ECHR can also be brought to bear upon the opposing argument: that the State should *refrain* from measures that go against a person's wishes. As already stated, Article 2 plays an important role in issues concerning life and death; it is concerned with both the beginning of life (for example, abortion), and the end of life (for example, euthanasia). The role of Article 2 in procedures concerning euthanasia and suicide by prisoners or detainees, although both are concerned with the end of life, differs substantively. In matters concerning suicide, Article 2, as we have seen, creates positive obligations for a State and its authorities to protect the right to life of its prisoners and detainees. In the context of euthanasia, however, Article 2 can be put forward as an argument to protect a person's right to choose whether or not to go on living. A remarkable case in this respect is that of *Pretty*.

In the *Pretty* case, Mrs Pretty asked for immunity from prosecution for her husband in assisting her to commit suicide because she was suffering from a degenerative and incurable illness that had paralysed her. She brought her case before the ECtHR, arguing that domestic United Kingdom law on assisted suicide infringed her rights under, *inter alia*, Article 2 ECHR. Pretty argued that Article 2 protects the right to life and not life itself, while the sentence concerning deprivation of life was directed towards protecting individuals from third parties, namely, the State and public authorities, and not from themselves. In her opinion, Article 2 therefore confirms that it is for the individual to choose whether or not to go on living and protects her right to die to avoid inevitable suffering and indignity as the corollary of the right to life. According to her, this is a different situation from *Keenan*, in which the obligation to prevent a man from taking his own life only arose because he was a prisoner and, due to his mental illness, lacked the capacity to make a rational decision to end his life.[103] In response, the British Government

[103] ECtHR 29 April 2002, *Pretty v the United Kingdom,* App. No. 2346/02, paragraph 35.

had submitted that Article 2, guaranteeing one of the most fundamental rights, primarily imposes a negative obligation. In their view, the right to die was not the corollary, but the antithesis of the right to life.[104]

The ECtHR ruled that it was not persuaded that "the right to life" guaranteed in Article 2 could be interpreted as involving a negative aspect. Although Article 11 ECHR, on the freedom of association, had been found to involve not only a right to join an association but a corresponding right not to be forced to join an association, the ECtHR observed that the notion of a freedom implies some measure of choice as to its exercise. Article 2 ECHR is phrased in different terms, and is unconcerned with issues relating to the quality of life or what a person chooses to do with his life. To the extent that these aspects are recognised as so fundamental to the human condition that they require protection from State interference, they may be reflected in the rights guaranteed by other articles of the ECHR, or in other international human rights instruments. The ECtHR proceeded by stating that: "Article 2 cannot, without a distortion of language, be interpreted as conferring the diametrically opposite right, namely a right to die; nor can it create a right to self-determination in the sense of conferring on an individual the entitlement to choose death rather than life." According to the ECtHR, the right to die, whether at the hands of a third person or with the assistance of a public authority, cannot be derived from Article 2.[105] Accordingly, the ECtHR concluded that there was no violation of Article 2 ECHR.

Unlike the abovementioned cases that dealt with the positive obligation to protect life, the *Pretty* case was concerned with the negative aspect of Article 2. In this case, the ECtHR is clear: it does not involve a negative aspect and no right to die can be established. That the ECtHR leaves it to Member States to decide upon euthanasia and assisted suicide is not very remarkable as euthanasia is a highly sensitive topic, and policies differ strongly within Europe. For this reason the ECtHR leaves a wide margin of interpretation to Member States to decide on such matters. Hunger strikes differ fundamentally from forms of euthanasia, because the hunger striker's motive is not to die. Still, it can be concluded that, since *Pretty* shows that no right to die can be established on the basis of Article 2, this Article does not provide protection against force-feeding by the State or its authorities. Article 2 only establishes a positive obligation for State authorities to protect the life of the persons it has deprived of its liberty. For now, it suffices to say that Article 2 is usually invoked in procedures before the ECtHR in favour of the use of force-feeding of prisoners on hunger strike. In these cases, the interests of Articles 2, 3, and 8 ECHR will have to be balanced.

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104 Ibid., paragraph 36.

105 Ibid., paragraphs 39-40.

6. THE PRISONER'S AND DETAINEE'S RIGHT TO CONSENT TO AND REFUSE MEDICAL TREATMENT

In the previous chapter, I elaborated on the patient's right to refuse medical treatment as codified in international and European instruments. As seen in § 4 of this chapter, the ECtHR has adopted the theory of "justified limitations". According to this, prisoners and detainees are entitled to the rights and obligations as laid down in the ECHR, including Article 3 and 8 ECHR that protect them against forced medical treatment. The idea that prisoners and detainees have to consent before medical treatment can be administered is also captured in international and European instruments. I will elaborate on these standards, including Article 3 and 8 ECHR, below.

6.1. INTERNATIONAL STANDARDS

None of the above-mentioned UN documents explicitly establishes a right to informed consent for prisoners and detainees. The UN Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment only notes under Principle 22 that "no detained or imprisoned person shall, even with his consent, be subjected to any medical or scientific experimentation which may be detrimental to his health" and under Principle 24 "a proper medical examination shall be offered to a detained or imprisoned person as promptly as possible after his admission to the place of detention or imprisonment, and thereafter medical care and treatment shall be provided whenever necessary".[106] This medical examination is not obligatory, as it is only "offered" to the prisoner. Furthermore, according to Principle 25, the prisoner has the right to request or petition a judicial or other authority for a second medical examination or opinion.

6.2. EUROPEAN STANDARDS

Rule 42.1 of the EPR contains a stipulation comparable to Principle 22 of the UN Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment: "The medical practitioner or a qualified nurse […] shall see every prisoner as soon as possible after admission, and shall examine them unless this is

[106] The UN Standard Minimum Rules for the Treatment of Prisoners contain a comparable Rule 24: "The medical officer shall see and examine every prisoner as soon as possible after his admission and thereafter as necessary, with a view particularly to the discovery of physical or mental illness and the taking of all necessary measures; the segregation of prisoners suspected of infectious or contagious conditions; the noting of physical or mental defects which might hamper rehabilitation, and the determination of the physical capacity of every prisoner for work."

obviously unnecessary." According to Van Zyl Smit and Snacken, this rather strange formulation "unless it is obviously unnecessary" is designed to lessen the possibility that prisoners may be examined against their will.[107] Furthermore, Rule 48.1 and 48.2 of the EPR are clear as far as experiments on prisoners are concerned: prisoners may not be subjected to experiments without their consent, and experiments that may result in physical injury, mental distress or other damage to health are prohibited. Article 69.1 of the Recommendation on the European Rules for juvenile offenders subject to sanctions or measures states that "[t]he provisions contained in international instruments on medical care for the physical and mental health of detainees are applicable also to juveniles deprived of their liberty".[108]

In its Third General Report, the CPT goes extensively into the issue of patients' consent and confidentiality. These statements go beyond the EPR. In this Report, the CPT stresses that freedom of consent and respect for confidentiality are fundamental rights that should apply equally in prisons and other places of detention. This is of the utmost importance, especially in these settings, since patients cannot choose their own doctor.[109] In its documents, the CPT refers consistently to patients who are deprived of their liberty as "patients" instead of referring to them as prisoners or detainees. According to the CPT, patients should be provided with all relevant information (if necessary in the form of a medical report) concerning their condition, the course of their treatment and the medication prescribed to them. Preferably, patients should have the right to consult their medical files, unless this is inadvisable from a therapeutic standpoint.[110] Every patient who is "capable of discernment" is free to refuse treatment or any other medical intervention. "Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances which are applicable to the population as a whole." This is different in situations in which the patient's decision conflicts with the doctor's general duty of care, for example if the patient has mutilated himself as a form of protest.[111] This opinion of the CPT is in line with the ECtHR line of reasoning: prisoners and detainees enjoy all the rights as laid down in the ECHR, which includes the right to consent to and refuse medical treatment according to

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107 Van Zyl Smit & Snacken 2008, p. 165. In its Third General Report, the CPT also stresses the importance of a first medical screening when somebody is taken in custody. "When entering prison, all prisoners should without delay be seen by a member of the establishment's health care service. In its reports to date the CPT has recommended that every newly arrived prisoner be properly interviewed and, if necessary, physically examined by a medical doctor as soon as possible after his admission." *3rd General Report,* CPT/Inf (93) 12, paragraph 33.

108 Recommendation of the Committee of Ministers on the European Rules for juvenile offenders subject to sanctions or measures, No. R. (2006)2. Adopted by the Committee of Ministers on 5 November 2008 at the 1040th meeting of the Ministers' Deputies.

109 *3rd General Report,* CPT/Inf (93) 12, paragraph 45.

110 Ibid., paragraph 46.

111 Ibid., paragraph 47.

Article 8 ECHR. Article 8 ECHR is a non-absolute right, which may by restricted, but only when adequately justified (cf. the doctrine of "justified limitations", see § 4 of this chapter).

6.2.1. The Recommendation concerning the Ethical and Organisational Aspects of Health Care in Prison

The Recommendation concerning the Ethical and Organisational Aspects of Health Care in Prison by the Committee of Ministers of the Council of Europe is most explicit in phrasing informed consent for prisoners and detainees. It states under Recommendation 14 that

> "Unless inmates suffer from any illness which renders them incapable of understanding the nature of their condition, they should always be entitled to give the doctor their informed consent before any physical examination of their person or their body products can be undertaken, except in cases provided for by law. The reasons for each examination should be clearly explained to, and understood by, the inmates. The indication for any medication should be explained to the inmates, together with any possible side effects likely to be experienced by them."

In this document, the terms prisoner, detainee, detained person and inmate appear. For this reason, although no definition appears in the document, in my opinion it can be concluded that this Recommendation concerns all persons in custody. The Recommendation mentions that for both examination and medical treatment, the prisoner's and detainee's consent is required and that he should be adequately informed to this end. According to this Recommendation, prisoners are equally entitled to freedom of consent as persons at liberty. Derogation from this principle should therefore be based upon law and be guided by the same principles which are applicable to the population as a whole. These principles are also applicable to juveniles deprived of their liberty. The Recommendation concerning juvenile offenders subject to sanctions or measures under 72.1 stipulates that "medical interventions shall be made only on medical grounds and not for purposes of maintaining good order or as a form of punishment", and "the same ethical principles and principles of consent governing medical interventions in free society shall be applied".[112]

It is clear that the above-mentioned documents, although often authoritative, are not binding on States, but solely provide guidelines. For this reason, it is interesting to review the case law of the ECtHR to investigate how it goes about the matter of a prisoner's or detainee's right to consent to and refuse medical treatment and the possibilities to limit these rights and apply forced medical treatment in concrete cases.

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[112] Recommendation CM/Rec(2008)11 of the Committee of Ministers to member states on the European Rules for juvenile offenders subject to sanctions or measures (Adopted by the Committee of Ministers on 5 November 2008 at the 1040th meeting of the Ministers' Deputies).

Before going into the case law of the ECHR, I will elaborate on Articles 3 and 8, and their connection, a little further.

6.2.2. Protection against forced medical treatment on the basis of Articles 3 and 8 ECHR

Articles 3 and 8 ECHR provide protection for prisoners and detainees against forced medical treatment. Article 3 ECHR protects persons who are deprived of their liberty against torture, inhuman or degrading treatment or punishment. As stated in the previous chapter, the ECtHR has acknowledged that the right to physical integrity is safeguarded under Article 8 ECHR. Forced medical treatment of competent patients interferes with their right to physical integrity. As I have shown in § 4 of this chapter, the ECtHR has adopted the doctrine of "justified limitations", which includes that prisoners and detainees are still entitled to the rights included in the ECHR, including the prohibition of torture, inhuman or degrading treatment or punishment of Article 3 ECHR and the right to respect for private and family life of Article 8 ECHR. Article 3 ECHR is absolute and cannot be limited, either for people who are free, or for prisoners and detainees. The right to respect for private and family life of Article 8 ECHR, can be limited for prisoners and detainees, although this has to be adequately justified, according to the ECtHR.

6.2.2.1. The absolute character of Article 3 ECHR

As already stated, Article 3 is an absolute right that prohibits torture and inhuman or degrading treatment or punishment. Article 3 is fundamental within the ECHR. As the ECtHR frequently reiterates, "Article 3 enshrines one of the most fundamental values of democratic societies". Unlike most of the substantive clauses of the ECHR, Article 3 makes no provision for exceptions. The prohibition of torture and inhuman or degrading treatment or punishment is absolute; derogation is not even permitted in the event of a public emergency that threatens the life of the nation. In the 2010 case of *Gäfgen*, the Grand Chamber of the ECtHR reiterated the absolute character of Article 3 ECHR and ruled that not only does torture constitute a violation of Article 3 ECHR, but also the threat of torture (in this case in order to make the suspect disclose the whereabouts of a kidnapped German boy).[113] Even in the most difficult circumstances, such as in the fight against terrorism and organised crime, the ECHR prohibits in absolute terms torture and inhuman or degrading treatment or punishment, irrespective of the conduct of the person concerned. The nature of the offence allegedly committed by the applicant is therefore irrelevant for the purposes of Article 3.[114]

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113 ECtHR 1 June 2010, *Gäfgen v Germany*, App. No. 22978/05 (Grand Chamber).

114 ECtHR 1 June 2010, *Gäfgen v Germany*, App. No. 22978/05 (Grand Chamber), paragraph 87.

The prisoner and detainee have to consent before medical treatment may be administered. In assessing evidence for this consent by the patient, the ECtHR has generally applied the standard of proof "beyond reasonable doubt". Such proof may follow from "the coexistence of sufficiently strong, clear and concordant interferences or of similar unrebutted presumptions of fact". Where the events at issue lie wholly, or in large part within the exclusive knowledge of the authorities, as is the case with persons who are deprived of their liberty, this is different; the burden of proof to show that the prisoner or detainee has given consent to his treatment then lies upon the State.[115] The medical file of the prisoner or detainee plays an important role in the assessment of an alleged breach of informed consent.

6.2.2.2. The terms of Article 3 ECHR

What qualifies as torture, and inhuman or degrading treatment or punishment in the sense of Article 3 ECHR? In the *Greek* case, the EComHR shed light on the difference between the different terms prohibited under Article 3: "It is plain that there may be treatment to which all these descriptions apply, for all torture must be inhuman and degrading treatment, and inhuman treatment also degrading." According to the EComHR, the term torture is used to describe "inhuman treatment, which has a purpose (such as the obtaining of information or confession, or the infliction of punishment), and it is generally an aggravated form of inhuman treatment". The EComHR furthermore noted that: "The notion of inhuman treatment covers at least such treatment as deliberately causes severe suffering, mental or physical, which, in the particular situation, is unjustifiable".[116] In more recent cases, the ECtHR has ruled that treatment was "inhuman" because, *inter alia*, it was premeditated, was applied for hours at a stretch, and caused either actual bodily injury or intense physical and mental suffering.[117] With regard to the difference between torture and inhuman treatment, the ECtHR ruled in *Ireland v the United Kingdom* that this difference "derives principally from a difference in the intensity of the suffering inflicted". The term torture could only be applied for "deliberate inhuman treatment causing very serious and cruel suffering."[118] In addition to the severity of the treatment, there must, according to the Grand Chamber of the ECtHR, be a purposive element, as has been recognised in the UN Convention against Torture and Other Cruel Inhuman

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115 ECtHR 27 June 2000, *Salman v Turkey* (Grand Chamber), App. No. 21986/93 (Grand Chamber), paragraph 100, and ECtHR 7 October 2008, *Bogumil v Portugal,* App. No. 35228/03, paragraph 73.

116 EComHR Report of 5 November 1969, Denmark, Norway, Sweden and the Netherlands v Greece (Greek case), Yearbook of the European Convention on Human Rights XII bis (1969).

117 ECtHR 6 April 2000, *Labita v Italy,* App. No. 26772/95 (Grand Chamber), paragraph 120.

118 ECtHR 18 January 1978, *Ireland v the United Kingdom,* App. No. 5310/71, paragraph 167.

or Degrading Treatment or Punishment, which defines torture as the intentional infliction of severe pain and suffering.[119]

For the designation "degrading treatment", no purposive element is required. According to the EComHR in the *Greek* case, "[t]reatment or punishment of an individual may be said to be degrading if it grossly humiliates him before others or drives him to act against his will or conscience".[120] More recently, the ECtHR has added that treatment can be considered degrading "when it was such as to arouse in its victims feelings of fear, anguish and inferiority capable of humiliating and debasing them and possibly breaking their physical or moral resistance".[121]

As can be concluded from the *Greek* case, the difference between the terms is a matter of degree. No clear-cut, abstract, comprehensive or absolute standard of defining the scope of Article 3 exists. The question of whether treatment or punishment is inhuman or degrading must be judged by the circumstances of the case and the prevalent views of the time.[122] This reflects the fact that the ECHR is considered to be a "living instrument": the ECHR must be applied in the light of prevailing conditions.[123] Changes in European society and thinking may change the interpretation of the ECHR articles; Article 3 therefore must be given a dynamic interpretation. The "living instrument" doctrine may mean that certain acts which were classified in the past as inhuman or degrading treatment, may now (or in the future) be classified as torture. The ECtHR takes the view that "the increasingly high standards being required in the area of the protection of human rights and fundamental liberties correspondingly and inevitably require greater firmness in assessing breaches of the fundamental values of democratic societies".[124] This "living instrument" doctrine has influenced and also broadened the scope of the protection of prisoners and detainees under Article 3 ECHR.[125]

The CPT uses the term ill-treatment for acts that qualify as torture or as inhuman or degrading treatment. In this study, I will also use the term ill-treatment to refer to such acts as prohibited under Article 3 ECHR.

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119 ECtHR 27 June 2000, *Salman v Turkey,* App. No. 21986/93 (Grand Chamber), paragraph 114, described by Van Dijk et al. 2006, p. 407.

120 EComHR Report of 5 November 1969, *Denmark, Norway, Sweden and the Netherlands v Greece* (*Greek* case), Yearbook of the European Convention on Human Rights XII bis (1969).

121 ECtHR 13 May 2008, *Juhnke v Turkey,* App. No. 52515/99, paragraph 70, and ECtHR 28 January 1994, *Hurtado v Switzerland,* App. No. 17549/90, paragraph 67.

122 Van Dijk et al. 2006, p. 412.

123 ECtHR 25 April 1978, *Tyrer v the United Kingdom,* App. No. 5856/72, paragraph 31.

124 ECtHR 28 July 1999, *Selmouni v France,* App. No. 25803/94 (Grand Chamber), paragraph 101.

125 See, *inter alia*, ECtHR 25 September 1997, *Aydin v Turkey*, App. No. 23178/94 (Grand Chamber), and ECtHR 27 November 2003, *Henaf v France,* App. No. 65436/01.

6.2.2.3. A minimum level of severity

Although Article 3 ECHR is formulated in absolute terms, in its application it may not always be as absolute as expected. This is not because this Article's restrictions on the rights are laid down in the Article itself, such as is the case with Article 8 ECHR for example, but that a certain threshold limit exists for acts that are prohibited by Article 3. The ECtHR has ruled that ill-treatment must attain a minimum level of severity to fall within the scope of Article 3. "The assessment of this minimum is, in the nature of things, relative; it depends on all the circumstances of the case, such as the duration of the treatment, its physical or mental effects and, in some cases, the sex, age and state of health of the victim, etc."[126] A certain act of ill-treatment may violate Article 3 in one case, while the same act may not violate Article 3 if the victims differ in sex, age and state of health. Although the purpose of such treatment is a factor to be taken into account, the absence of the intention to humiliate or to debase the victim does not inevitably lead to the finding that Article 3 ECHR has not been violated. It may be that an act attains this minimum level of severity, even when it was not the intention of the authorities to humiliate or debase the prisoner or detainee concerned.[127] This minimum level of severity must go beyond the consequences to be expected from measures taken on a purely disciplinary level.[128] In this respect, the ECtHR has consistently stressed that the suffering and humiliation involved must in any event go beyond that inevitable element of suffering or humiliation connected with a given form of legitimate treatment or punishment.[129] It can be concluded that there is no abstract and clear-cut standard for treatment and punishment that is prohibited by Article 3 ECHR. It can sometimes be difficult to answer the question as to whether certain treatment or punishment was unpleasant or even harsh or whether it amounted to inhuman or degrading treatment in the sense of Article 3 ECHR. In this respect, national authorities are often allowed a certain degree of interpretation. This is illustrated by the case of *Ramirez Sanchez v France*, in which it was determined that exceptional circumstances in a particular case, such as the character of the applicant and the danger he posed, may strongly influence whether certain treatment reaches the minimum level of severity necessary to constitute ill-treatment within the meaning of Article 3 ECHR.[130]

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126 ECtHR 18 January 1978, *Ireland v the United Kingdom,* App. No. 5310/71, paragraph 162.

127 See, for example, ECtHR 19 April 2001, *Peers v Greece*, App. No. 28524/95, paragraph 74.

128 ECtHR 25 March 1993, *Costello-Roberts v the United Kingdom,* App. No. 13134/87, paragraph 32.

129 *Inter alia* ECtHR 25 April 1978, *Tyrer v the United Kingdom,* App. No. 5856/72, and ECtHR 26 October 2000, *Kudla v Poland,* App. No. 30210/96 (Grand Chamber).

130 EHRM 4 July 2006, *Ramirez Sanchez v France*, App. No. 59450/00.

6.2.2.4. Protection against forced medical treatment on the basis of Article 3 ECHR

Article 3 ECHR can provide protection against forced medical treatment if this treatment attains a minimum level of severity. Although most cases concerning forced medical treatment were examined in relation to Article 8 ECHR, in several cases the ECtHR has examined complaints in the context of forced medical interventions in prisoners and detainees under Article 3 ECHR (see, for example, the case of *Jalloh* as discussed in § 6.2.2.6 of this chapter and the cases on force-feeding hunger strikers as discussed in Chapter 5). As with Article 8 ECHR cases, the ECtHR has accepted that, for Article 3 ECHR cases, forced medical treatment interferes with a person's right to physical integrity. In a 2011 case of a Slovakian woman of Roma ethnic origin who had been sterilised after giving birth, the ECtHR reiterated that

> "the very essence of the Convention is respect for human dignity and human freedom. It has held that in the sphere of medical assistance, even where the refusal to accept a particular treatment might lead to a fatal outcome, the imposition of medical treatment without the consent of a mentally competent adult patient would interfere with his or her right to physical integrity."[131]

Applied to the facts of the case, the ECtHR noted that sterilisation constitutes a major interference with a person's reproductive health, and it may not be performed without the informed consent of a mentally competent adult patient. The sterilisation procedure, including the manner in which the applicant was requested to agree to it – V.C. was pressured to consent while she was in a supine position and in pain resulting from several hours' labour – was liable to arouse in her feelings of fear, anguish and inferiority and to entail lasting suffering, consisting of disturbed relations with her husband and the Roma community as a result of the sterilisation. The treatment to which she was subjected attained the threshold of severity of Article 3 ECHR, and the ECtHR concluded that the Article had been violated.[132] If certain forced medical treatment does not attain the threshold of severity as needed to bring it within the scope of Article 3 ECHR, Article 8 ECHR can afford protection.

6.2.2.5. Protection against forced medical treatment on the basis of Article 8 ECHR

Alongside Article 3 ECHR, Article 8 ECHR encompasses a broad range of issues that are relevant in prisons and other places of detention, including forced medical treatment. As shown in Ch. 2, § 8.1, the ECtHR has acknowledged that the right

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131 ECtHR 8 November 2011, *V.C. v Slovakia,* App. No. 18968/07, paragraph 105.

132 ECtHR 8 November 2011, *V.C. v Slovakia,* App. No. 18968/07, paragraphs 106-120.

to make decisions concerning one's own body (in other words: the right to self-determination) forms a part of the notion of personal autonomy as laid down in Article 8 ECHR. Besides, under this Article the physical and psychological/moral integrity of a person is safeguarded. Forced medical treatment interferes with the right to private life as laid down in Article 8 ECHR. Article 8 ECHR thus requires both the patient's consent before a medical procedure can be performed and respect for the patient's refusal to be treated. The rights set out in the first paragraph of Article 8 ECHR are not absolute, but can be subject to restrictions as set out in the Article's second paragraph. This also applies to prisoners and detainees. If the prisoner's or detainee's right to private and family life of Article 8 ECHR is restricted, this needs to be adequately justified (see Ch. 3, § 4). The ECtHR has also explicitly ruled on the relevance of Article 8 ECHR for prisoners and detainees, stating that "the notion of private life [of Article 8 ECHR] is a broad one and is not susceptible to exhaustive definition; it may, depending on the circumstances, cover the moral and physical integrity of the person […]. The Court further recognises that these aspects of the concept extend to situations of deprivation of liberty."[133]

In certain circumstances, Article 8 ECHR affords protection when certain acts or conditions in prisons or other places of detention do not attain the minimum level of severity required by Article 3 ECHR. This is also acknowledged by the ECtHR.

> "Where a measure falls short of Article 3 treatment, it may, however, fall foul of Article 8 of the Convention, which, *inter alia*, provides protection of physical and moral integrity under the respect of private life […]. In this connection, the Court reiterates that a decision imposing a medical intervention in defiance of the subject's will would give rise to an interference with respect for his or her private life, and in particular his or her right to physical integrity."[134]

Normal restrictions and limitations consequent on prison life and discipline during lawful detention do not interfere with the prisoner's private and family life laid as down in Article 8 ECHR.[135]

6.2.2.6. Restrictions on the right to private life of Article 8 ECHR

As has been mentioned, the rights set out in Article 8 ECHR are not absolute. It is an explicitly qualified right that provides protection as formulated in the first paragraph, but is subject to restrictions as set out in the Article's second paragraph. This paragraph states that, in certain situations, the right to private life and its elements

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133 ECtHR 16 December 1997, *Raninen v Finland,* App. No. 20972/92, paragraph 63.

134 ECtHR 13 May 2008, *Juhnke v Turkey,* App. No. 52515/99, paragraph 71.

135 ECtHR 16 May 2002, *D.G. v Ireland,* App. No. 39474/98, paragraph 105 and ECtHR 16 December 1997, *Raninen v Finland,* App. No. 20972/92, paragraphs 63-64.

may be restricted. The rights in Articles 8-11 all contain second paragraphs that contain limitations to the rights that are mentioned in the first paragraphs. If the ECtHR identifies interference with a right provided in these provisions, a further examination is required to determine whether this interference can be justified on the basis of the limiting factors as laid down in the Article itself and elaborated upon in the ECtHR case law. The limitation clauses attached to Articles 8-11 ECHR demand that

1) any interference with the ECHR's rights is "in accordance with the law" or "prescribed by law";
2) this interference must pursue any of the legitimate aims that are exhaustively laid down in the second paragraph; and
3) this interference must be considered "necessary in a democratic society".[136]

The ECtHR usually examines these three standards in sequence. Case law shows that the ECtHR stresses the fundamental importance of the rights of Articles 8-11 and that exceptions to these rights should be narrowly interpreted and any restriction must be convincingly established.

The first standard, that any interference with the ECHR's rights is "in accordance with the law" or "prescribed by law", requires that the national legal provision interfering with a right must be accessible to the citizens (the test of accessibility). This includes that the law that must be formulated in such a way that citizens can foresee the exact scope and meaning of the provision so that they can adapt their conduct (the foreseeability or precision test), and that adequate safeguards against abuses must be offered in a manner that would clearly demarcate the extent of the authorities' discretion and define the circumstances in which it is to be exercised. The second standard requires that the interference must pursue any of the legitimate aims laid down in paragraph 2 of the Article, i.e. national security, public safety or the economic well-being of the country, the prevention of disorder or crime, the protection of health or morals, or the protection of the rights and freedoms of others. This is an exhaustive enumeration; the right to private and family life of Article 8 ECHR can only be restricted on the basis of these aims. Still, the EComHR and ECtHR have very rarely found a violation of ECHR by reference to this standard. Van Dijk and Van Hoof explain this by referring to "the strong commitment to democratic governance and the protection of human rights, which is a precondition for membership of the Council of Europe". A more substantial reason in their opinion, however, is that "the assessment of this standard is normally carried out in conjunction with the third standard 'necessary in a democratic society', and in particular, with the application of

[136] Van Dijk et al. 2006, pp. 334-335.

proportionality".[137] This is reinforced by Emmerson, Ashworth and Macdonald, who state that with alleged violations of Articles 8 to 11 ECHR, the ECtHR will consider this matter in two stages. First, it will inquire whether the interference pursued one of the stated legitimate aims. "More often than not, this turns out to be uncontroversial." According to them, the most significant problems, however, arise in the second stage, when the ECtHR inquires whether there is a "reasonable relationship of proportionality" between the interference and the aim sought to be achieved.[138] Gerards notes in this respect that the legitimate aims mentioned in the limitation clauses are formulated so broadly and are so numerous that almost all general interests that are served by a certain government action are covered by one of those legitimate aims. Accordingly, the legitimate aims do not play a significant role in the case law of the ECtHR.[139] In general, it can be said that the third standard, that the interference must be considered "necessary in a democratic society", has raised the most significant interpretation issues. The ECtHR has ruled that the notion of "necessary" corresponds, *inter alia*, to "a pressing social need" and must be "proportionate to the legitimate aim pursued". States enjoy a certain degree of interpretation in evaluating such a pressing social need. The principle of proportionality entails a subsidiary requirement that the reasons adduced by a State for justifying interference must be both "relevant and sufficient".[140] For an exhaustive elaboration on these three standards and their application, I refer to the authoritative work on the ECHR by Van Dijk et al.[141]

Exceptions to private and family life as laid down in the first paragraph of Article 8 ECHR can be found in the case law of the ECtHR. General interests of society, for example, can play a role in determining whether an individual's personal autonomy must respected.[142] In the sphere of personal autonomy, individuals are at liberty to exercise their freedoms, and the State and other parties must refrain from any involvement in their actions. But where does the individual's personal autonomy cease to exist and the State or other parties can legitimately impose restrictions on the exercise of this personal autonomy?

In the 1997 case of *Laskey, Jaggard and Brown* – a case of violent sadomasochistic actions between men in a private setting – the ECtHR noted in assessing a violation under Article 8 ECHR that States are entitled "to regulate, through the operation of the criminal law, activities which involve the infliction of physical harm. This is so whether the activities in question occur in the course of sexual

137 Van Dijk et al. 2006, p. 340.

138 Emmerson, Ashworth & Macdonald 2007, p. 105.

139 Gerards 2011, p. 133.

140 Van Dijk et al. 2006, pp. 333-350, with references to relevant ECtHR case law.

141 Ibid.

142 See, for example, the cases of ECtHR 11 July 2002, *I v UK,* App. No. 25680/94 and ECtHR 11 July 2002, *Christine Goodwin v UK,* App. No. 28957/95 (Grand Chamber).

conduct or otherwise."[143] In the 2002 case of *Pretty*, the ECtHR reiterated this rule, but formulated it slightly differently: "States are entitled to regulate through the operation of the general criminal law activities which are detrimental to the life and safety of other individuals." [144] Accordingly, the right to private life of Article 8 ECHR may be restricted when its exercise is harmful to the life and safety of others. But may the State also legitimately intervene when no harm to the life and safety of other individuals is caused, but somebody "only" causes harm to his own life or safety, such as with hunger strikes? In the case of *Pretty*, the ECtHR also emphatically stated that the notion of personal autonomy may also include the opportunity to pursue activities that are physically or morally harmful or dangerous for the individual concerned.[145] In this way, the ECtHR seems to allow for room for individuals to make choices that are harmful to themselves, such as is the case with hunger strikes. In such cases, the State must refrain from any involvement in the individual's actions. Still, in the case of *Pretty*, the ECtHR added that where the conduct poses a danger to health or, arguably, where it is of a life-threatening nature, it can allow for compulsory or criminal measures impinging on private life within the meaning of Article 8, first paragraph, of the ECHR. Nevertheless, such measures need justification in terms of the second paragraph. Besides, the ECtHR noted that "[t]he more serious the harm involved the more heavily will weigh in the balance considerations of public health and safety against the countervailing principle of personal autonomy".[146]

It can be concluded that, according to the ECtHR, the right to private life of Article 8 ECHR may be restricted by the State when harmful to the life and safety of others, but also when harmful to the person's own health or life, especially when of a serious nature. Still, such measures need to be justified on the basis of Article 8, second paragraph, of the ECHR. It can be concluded that the right to private life of Article 8 ECHR is not absolute. This is in line with the conclusion of the ECtHR in the case of *Pretty* in relation to the right to life of Article 2 ECHR. In this case, the ECtHR was opposed to accepting the diametrically opposite right, the right to die. In this way, individual persons do not have an absolute entitlement to a self-chosen death, and their right to self-determination, in this way, is subjected to limitation.

In several cases, the ECtHR has ruled on forced medical treatment and examination under Article 8 ECHR. As discussed in § 6.2.2, forced medical treatment in principle interferes with the concept of private life as laid down in Article 8 ECHR. Still, in

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143 ECtHR 19 February 1997, *Laskey, Jaggard and Brown v the United Kingdom,* App. Nos. 21627/93, 21628/93, 21974/93, paragraph 43.

144 ECtHR 29 April 2002, *Pretty v the United Kingdom,* App. No. 2346/02, paragraph 74. See also Ch. 2, § 8.1.

145 ECtHR 29 April 2002, *Pretty v the United Kingdom,* App. No. 2346/02, paragraph 62.

146 Ibid.

case law it is acknowledged that forced medical treatment under circumstances can also be justified on the basis of Article 8, second paragraph, of the ECHR.[147]

Considering the research topic, an interesting case in this respect is that of *Jalloh*.[148] The application of emetics in the case of *Jalloh* is similar to the application of force-feeding: as Jalloh had not consented to his treatment, he was immobilised by four police officers, and the doctor forcibly administered a salt solution and the emetic syrup through a tube introduced into his stomach through his nose. Furthermore, the doctor injected Jalloh with apomorphine, another emetic that is a derivative of morphine. This approach can be compared with the most common procedure of force-feeding prisoners and detainees on hunger strike as described in Chapter 1: force-feeding also requires force to restrain the hunger striker, includes the use of a nasogastric tube to administer the feeding, and the hunger striker is often given an anaesthetic and pain killers. The ECtHR has had due regard to the similarities of the two procedures, as it refers under "relevant principles" to the *Herczegfalvy* and *Nevmerzhitsky* cases and reiterates that "[a] measure which is of therapeutic necessity from the point of view of established principles of medicine cannot in principle be regarded as inhuman and degrading. […] This can be said, for instance, about force-feeding that is aimed at saving the life of a particular detainee who consciously refuses to take food."[149] Neither procedure, as the Grand Chamber of the ECtHR notes in the *Jalloh* case, is without risk to the recipient's health. In this case, the alleged violations were not only based upon Article 8, but also on Article 3 ECHR (similar to most cases of force-feeding of prisoners on hunger strike, see Chapter 5). In the *Jalloh* case, a person was suspected of having swallowed a tiny plastic bag with drugs (a so-called "bubble") and was forcibly administered emetics in order to provoke its regurgitation. The Grand Chamber of the ECtHR acknowledged that "[e]ven where it is not motivated by reasons of medical necessity, Articles 3 and 8 of the Convention do not as such prohibit recourse to a medical procedure in defiance of the will of a suspect in order to obtain from him evidence of his involvement in the commission of a criminal offence".[150] Such evidence may consist of the taking of blood or saliva samples. However, such forcible medical intervention must be convincingly justified on the basis of the facts of a particular case. When procedures are of a particularly intrusive nature, this requires a strict scrutiny of all the circumstances involved. Due regard must be paid to the seriousness of the offence at issue. Authorities must also convincingly show that they have explored alternative methods of recovering the evidence. The procedure must furthermore not entail any risk of lasting detriment to the suspect's health.[151]

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147 See, for instance, ECtHR 5 July 1999, *Matter v Slovakia*, App. No. 31534/96

148 ECtHR 11 July 2006, *Jalloh v Germany* (Grand Chamber), App. No. 54810/00 (Grand Chamber).

149 ECtHR 11 July 2006, *Jalloh v Germany,* App. No. 54810/00, paragraph 69.

150 Ibid., paragraph 70.

151 Ibid., paragraphs 70-71.

The Grand Chamber of the ECtHR ruled that the authorities had subjected Jalloh to grave interference with his physical and mental integrity against his will. They had forced him to regurgitate, not for therapeutic reasons, but in order to retrieve evidence they could equally have obtained by less intrusive methods (by waiting for the drugs to come out naturally). The manner in which the impugned measure had been carried out was liable to arouse in the applicant feelings of fear, anguish and inferiority that were capable of humiliating and debasing him. Furthermore, the procedure entailed risks to the applicant's health and the measure had been implemented in a way which had caused the applicant both physical pain and mental suffering. Accordingly, the ECtHR concluded that there had been a violation of Article 3 of the Convention.[152] In view of this conclusion, the ECtHR found that no separate issue arose under Article 8 ECHR.

Still, it is remarkable that the ECtHR states that "[e]ven where it is not motivated by reasons of medical necessity, Articles 3 and 8 of the Convention do not as such prohibit recourse to a medical procedure in defiance of the will of a suspect in order to obtain from him evidence of his involvement in the commission of a criminal offence". States thus may use forced medical treatment to obtain evidence from suspects, as long as this medical treatment meets certain criteria. Here, the ECtHR seems to leave room for medical procedures which are not medically necessary, but are needed to obtain evidence about a criminal offence.

7. CONCLUSIONS

Just like other citizens, prisoners and detainees can find themselves in need of medical care. Prisoners and detainees are dependent on the State and institutional authorities to provide them with necessary medical care. In Article 12 ICESCR a right to health care for prisoners and detainees is acknowledged. In Rule 39 of the EPR such a right is explicitly acknowledged, as covering not only adequate health care in prisons and other places of detention, but also a duty for the State and custodial authorities to, *inter alia*, guarantee healthy custodial conditions for prisoners and detainees. The international human rights regime emphasises the importance of a well-arranged and adequate health care service, which is available for all those deprived of their liberty as an important safeguard against human rights abuses. The principle of equivalence of care implies that prisons and other places of detention have to provide a standard of health care that is equivalent to that available within the rest of the community. Several international human rights treaties protect persons who are deprived of their liberty against torture and inhuman or degrading treatment or punishment. Article 3 ECHR, for example, creates negative obligations for States to refrain from torture and inhuman or degrading treatment or punishment as well as

[152] Ibid., paragraphs 82-83.

positive obligations for States and custodial authorities to provide adequate health care to prisoners and detainees. Article 2 ECHR, which contains the right to life, is also especially important in situations in which persons are deprived of their liberty, as these persons find themselves in a vulnerable position because they face a higher risk of their right to life being violated. Article 2 ECHR creates positive obligations for the State to protect the life of prisoners and detainees. On the basis of Article 2 ECHR, if information indicates that a prisoner or detainee poses a real and immediate risk of suicide, State authorities have to take appropriate steps to protect his life. Human rights of persons who are deprived of their liberty may not be more restricted than is inherent to their deprivation of liberty. The ECtHR abandoned the doctrine of inherent limitations in the *Vagrancy* and *Golder* cases. Nowadays, it is recognised that persons who are deprived of their liberty are entitled to all the rights and freedoms laid down in the ECHR, including Article 3. Restrictions on non-absolute rights, such as the right to respect for private and family life of Article 8 ECHR, that contains the patient's right to consent to and refuse medical treatment, must be adequately justified. Articles 3 and 8 ECHR protect prisoners and detainees against forced medical treatment. A certain threshold limit exists for acts which do and do not qualify as acts as prohibited under Article 3 ECHR. In certain circumstances, Article 8 ECHR affords protection when certain acts or conditions in prisons or other places of detention do not attain this minimum level of severity. The ECtHR has acknowledged that the notion of personal autonomy of Article 8 ECHR may also include the opportunity to pursue activities that are physically or morally harmful or dangerous for the individual concerned. The rights set out in Article 8 ECHR, however, are not absolute and can be subject to restrictions as set out in the Article's second paragraph. In its case law, the ECtHR has acknowledged, for example, that forced medical treatment may, under certain circumstances, be used for retrieving evidence in suspects in the interests of establishing the truth.

CHAPTER FOUR

ARGUMENTS FOR AND AGAINST FORCE-FEEDING PRISONERS AND DETAINEES ON HUNGER STRIKE

1. INTRODUCTION

In the past two chapters, I have discussed the concepts of patient autonomy, the right to self-determination, and informed consent in general and for prisoners and detainees in particular. In this chapter, I will apply these notions to the issue of force-feeding prisoners and detainees on hunger strike. The notions discussed before will especially be important for the first part of this chapter, as I will investigate the arguments that can be advanced against force-feeding in this part. In the second part of this chapter, I will explore all the arguments that can be advanced in favour of force-feeding. As will be shown in this chapter, in arguing both *pro* and *contra* force-feeding, many different points of view can be advanced which are often closely related and intertwined. To investigate the question of whether the use of force-feeding can be legitimate and, if so, under what circumstances, it is essential to have a clear overview of all the relevant arguments. In the literature on this topic, there is no such overview of arguments in favour of and against force-feeding prisoners and detainees on hunger strike.[1] Only a few articles go into the different arguments against force-feeding. These are all American articles, describing the State's potential interest in force-feeding prisoners on hunger strike; the State's interest in suicide prevention, the preservation of life, maintaining order and security in prisons; and the State's obligation to protect the health and welfare of persons in its custody as described in US case law.[2] Although these arguments do not play identical roles in the European debate on force-feeding, they are to a large extent reflected in some of the arguments in favour of force-feeding as described in the second part of this

[1] Welsh, though, provides a schematic overview of the human rights of prisoners and state interests and obligations in responding to hunger strikes in his chapter. Welsh 2009, p. 147.

[2] Tagawa 1983, p. 585 ff, Silver 2005, p. 642 ff and Ansbacher 1983, p. 102 ff.

chapter. In this chapter, I will provide an overview of all the relevant arguments, both for and against, from a European perspective. The arguments described here are derived from the literature, the case law of the ECtHR, and cases that have occurred in Germany, the Netherlands, and England and Wales. Where relevant, I will illustrate the arguments with relevant cases. Where possible, I will briefly explain the role of the different arguments in the discussion on force-feeding. I will often refer to the following chapters, in which the attitude of European and international institutions and national legislation of the Netherlands, England and Wales, and Germany vis-à-vis these different arguments will be discussed.

2. ARGUMENTS AGAINST FORCE-FEEDING PRISONERS AND DETAINEES ON HUNGER STRIKE

In the first part of this chapter I will investigate the arguments that can be advanced against force-feeding. These arguments support the view that hunger strikers should be allowed to begin and continue their strike, without intervention from third parties.

2.1. FORCE-FEEDING INFRINGES UPON THE PRISONERS' OR DETAINEES' RIGHT TO SELF-DETERMINATION

The most important, and most often cited, argument in both legal and (medical-) ethical debates against the use of force-feeding of hunger strikers is that force-feeding must not be applied because it infringes upon the hunger striker's right to self-determination. The right to self-determination, as a part of the broader notion of personal autonomy, was discussed in detail in Chapters 2 and 3. Here it suffices to say that these concepts play an important role in protecting prisoners and detainees from unwanted and intrusive medical treatment. The concept of personal autonomy in general and the right to self-determination in particular require a patient's informed consent before medical treatment can be performed. On the basis of the right to self-determination, force-feeding prisoners and detainees on hunger strike is therefore to be rejected.

2.2. FORCE-FEEDING IS A FORM OF TORTURE OR INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT

The second argument in favour of force-feeding is closely related to the first argument as illustrated above. In Chapter 1, I reviewed the methods of force-feeding. I showed that these methods of force-feeding are of a very invasive nature and entail a great deal of force to constrain the non-cooperative hunger striker. Because of the invasive methods of force-feeding, and the force that must be used to restrain

the hunger striker, it is frequently argued that force-feeding is a form of torture or inhuman or degrading treatment or punishment. It is not surprising that the ECtHR has never considered force-feeding within the margin of Article 8 ECHR (which contains the right to physical integrity), but has only dealt with this issue in the context of Article 3 ECHR: the codification of the fundamental value that prisoners and detainees should not be subjected to torture or inhuman or degrading treatment or punishment. The argument that force-feeding contravenes Article 3 ECHR has been the most important argument in procedures before the EComHR and ECtHR against force-feeding, as will be shown in Chapter 5.

2.3. FORCE-FEEDING CONTRAVENES MEDICAL ETHICS

The first two arguments against the use of force-feeding prisoners and detainees on hunger strike as illustrated above are the most important in the legal debate on the use of force-feeding of prisoners and detainees on hunger strike. Similar considerations, however, strongly influence the medical-ethical debate on force-feeding. This is not surprising as medical ethics are strongly concerned with the protection of the patient's human rights. International documents on medical ethics concerning hunger strikes contain provisions against force-feeding prisoners and detainees on hunger strike, especially those of the WMA. It is argued that, for the maintenance of the ethical integrity of the medical profession, physicians must not force-feed prisoners or detainees on hunger strike. (I will further elaborate on medical-ethical aspects of force-feeding and these WMA declarations in Ch. 5, § 2.2). Physicians and other medical professionals most often strongly oppose the use of force-feeding prisoners and detainees on hunger strike. They do so by highlighting the fact that force-feeding entails medical treatment against the patient's will, emphasising its intrusive character and the force that has to be applied to constrain the hunger striker, the medical risks, (Ch. 1, § 8), and the fact that force-feeding contravenes the Hippocratic Oath.

The Hippocratic Oath has always served as a guideline for the ethical behaviour of medical professionals. Nowadays, in many countries, graduating medical students take some form of the Hippocratic Oath, swearing that they will uphold a number of professional medical-ethical standards before starting to work as a physician. These oaths are often modern and strongly modified versions of the ancient Greek original. In 1979, the International Council of Prison Medical Services highlighted the relevance of the Hippocratic Oath for health professionals working in prison in the so-called Oath of Athens.[3] In the context of force-feeding, the Hippocratic

[3] "We, the health professionals who are working in prison settings, meeting in Athens on September 10, 1979 hereby pledge, in keeping with the spirit of the Oath of Hippocrates, that we shall endeavour to provide the best possible health care for those who are incarcerated in prison for whatever reasons, without prejudice and within our respective professional ethics. We recognize the right of the incarcerated individuals to receive the best possible health care. We undertake 1. To

Oath can be interpreted in a way that promotes force-feeding, but also in a way that opposes force-feeding. Some will emphasise that the Hippocratic Oath prescribes that physicians must preserve and protect human life, and must act in the patient's best medical interest (including measures such as force-feeding to promote the patient's well-being, even when this is against the patient's express wishes), while others will underline that the Hippocratic Oath prescribes that harm to the patient should be avoided, the relationship between the physician and patient should be based on trust, the patient's confidence must be maintained, and the patient's autonomy and will should be respected.

2.4. FORCE-FEEDING IS A VIOLATION OF THE HUNGER STRIKER'S FREEDOM OF EXPRESSION

As stated in the introduction to this book, hunger strikes are mostly used by people in a powerless position, when they have exhausted all their legal and other possibilities to protest. A hunger strike is often a last resort to voice certain opinions or desires for individuals or groups of people when no other mechanism is available. Hunger strikes are used as a means of protest, but also serve as a method of communication, both with the authorities and other prisoners or detainees and with the outside world. As Annas states, hunger strikers "would greatly prefer responses to their demands".[4] In my opinion, a hunger strike always conveys a message, whether it is a political message, dissatisfaction with custodial conditions or circumstances, or (decisions of) the authorities. Even if a hunger strike itself is not intended as a form of communication, once the purpose of the hunger strike is made known, it undoubtedly becomes a communicative act. For this reason, in the US, the hunger striker's right to communicate his strike decision and the condition upon which it will end is considered as an exercise of his first amendment right to freedom of expression.[5] Hunger strikes often cause much turmoil, both inside and outside the prison or place of detention. In this way, hunger strikes can be a powerful tool to voice certain opinions or desires for (groups of) prisoners and detainees.

The need to suppress the hunger striker's freedom of expression is felt to be most urgent if prisoners or detainees display an opinion that is not favourable to the authorities involved. It is not uncommon for prisoners and detainees on hunger

abstain from authorising or approving any physical punishment, 2. To abstain from participating in any form of torture, 3. Not to engage any form of human experimentation amongst incarcerated individuals without their informed consent, 4. To respect the confidentiality of any information obtained in the course of our professional relationships with incarcerated patients, 5. That our medical judgements be based in the needs of our patients and take priority over any non-medical matters". Quoted by Penal Reform International 2001, pp. 74-75.

4 Annas 1995, p. 1114.

5 Tagawa 1983, p. 583 ff, with references to US case law.

strike to express discontent about, *inter alia*, the conditions in which they are held or about decisions of the authorities involved (mostly the custodial authorities). By making their voices heard, hunger strikers may pose a threat to the authorities' reputation, in that they may damage or undermine their position. In such situations, the authorities may urge force-feeding, to prevent the hunger strikers from expressing their harmful message to the rest of the prison or other place of detention, as well as to the outside world. In these situations, force-feeding can be used to prevent hunger strikers from voicing their protest and to suppress their freedom of expression.[6] If force-feeding is applied, the function of the hunger strike as a method of communication is removed. Such authoritarian regimes in prisons and other places of detention are mostly found in non-democratic societies and oppressive regimes.

From a European perspective, freedom of expression is guaranteed under Article 10 ECHR. This right includes "freedom to hold opinions and to receive and impart information and ideas without interference by public authority and regardless of frontiers". Article 10 is not absolute: the freedom of expression is subject to the exceptions set out in the second paragraph, which reads as follows.

> "The exercise of these freedoms, since it carries with it duties and responsibilities, may be subject to such formalities, conditions, restrictions or penalties as are prescribed by law and are necessary in a democratic society, in the interests of national security, territorial integrity or public safety, for the prevention of disorder or crime, for the protection of health or morals, for the protection of the reputation or the rights of others, for preventing the disclosure of information received in confidence, or for maintaining the authority and impartiality of the judiciary."

For prisoners and detainees, the right to freedom of expression has different forms; the right to hold and express opinions, which includes the right to vote, and the right to receive and impart information, which includes access to the media.[7] As stated in Ch. 3, § 4, prisoners and detainees are equally entitled to all the rights in the ECHR. Such non-absolute rights as laid down in Article 10 can be limited, but this has to be adequately justified. Hunger strikes, in my opinion, fall under the right to hold and express opinions since, as stated above, they are often used to air certain ideas and beliefs to the outside world (or the "inside world" of the prison or other place of detention). Cases which concern this form of freedom of expression are mostly concerned with the right to vote.[8]

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6 This is often also the result of the feeling of being blackmailed by the hunger striker's action (see § 3.2 of this chapter).

7 For an elaboration on these forms; Van Zyl Smit & Snacken 2008, p. 249 ff.

8 The EComHR has long accepted certain restrictions on the freedom to receive and impart information and ideas, and interpreted the restriction of the prevention of disorder (as laid down in the second paragraph of Article 10 ECHR) very broadly, according to the doctrine of inherent limitations. See Ch. 3, § 4.

Yankov is an example of a case in which a prisoner expressed an opinion that was unfavourable to the custodial authorities.[9] In this case, Bulgarian prisoner Yankov alleged that Article 10 ECHR had been violated, because his manuscript for a book, in which he described his detention and the criminal proceedings against him, had been confiscated by the authorities before he could give it to his lawyer because it contained "offensive and defamatory statements against officers, investigators, judges, prosecutors and state institutions". In his manuscript, he called the prison warders "well-fed idlers" and "simple villagers", named a police officer "a provincial parvenu", and referred to prosecutors and investigators in general as "powerful unscrupulous people". As a punishment, Yankov's head was shaved and he was placed in solitary confinement for a week. In dealing with this case, the ECtHR stated that such interference constituted a violation of Article 10 ECHR, unless it is prescribed by law and is necessary in a democratic society in pursuance of a legitimate aim, as laid down in the second paragraph of the Article. In determining whether this measure was necessary in a democratic society, the ECtHR reiterated as a fundamental principles underlying its judgments in relation to Article 10 ECHR.

> "(i) Freedom of expression constitutes one of the essential foundations of a democratic society and one of the basic conditions for its progress and for each individual's self-fulfilment. Subject to paragraph 2 of Article 10, it is applicable not only to 'information' or 'ideas' that are favourably received or regarded as inoffensive or as a matter of indifference, but also to those that offend, shock or disturb. Such are the demands of that pluralism, tolerance and broadmindedness without which there is no 'democratic society'. As set forth in Article 10, this freedom is subject to exceptions, which must, however, be construed strictly, and the need for any restrictions must be established convincingly."[10]

In the present case, the ECtHR ruled that, because of the particular vulnerability of persons in custody, the punishment of prisoners who have allegedly made false accusations concerning the conditions of detention and acts of the penal authorities requires particularly solid justification in order to be considered necessary in a democratic society. Here, accusations concerning the conditions of detention and alleged offensive and defamatory statements were undoubtedly insulting, but they were far from being grossly offensive. Also, Yankov's remarks were never made public, the manuscript was not in a form ready for publication and there was no immediate danger of its dissemination, even if it had been taken out of the prison. The civil servants' feeling of being insulted by the remarks in the manuscript was not sufficient reason to punish the applicant. The ECtHR concluded that the

9 ECtHR 11 December 2003, *Yankov v Bulgaria,* App. No. 39084/97.

10 Ibid., paragraph 129.

intervention was not necessary in a democratic society and could therefore not be justified on the basis of Article 10, paragraph 2 ECHR.[11]

Force-feeding prisoners and detainees on hunger strike is obviously different from a prohibition to vote or an intervention as a result of an insulting manuscript, but, in my opinion, equally concerned with the scope of the freedom of expression as laid down in Article 10 ECHR. As stated in Ch. 3, § 4 and reiterated in the case of *Yankov*, it can be concluded that prisoners and detainees are equally entitled to the right to hold and express opinions, within the limits given in the second paragraph of Article 10 ECHR. Prisoners and detainees have the right to hold and express opinions, even if these opinions comment on and criticise the administration of justice and the officials involved in it. In my opinion, it can be argued that the ECtHR has made it clear that custodial authorities must accept criticism from prisoners and detainees. This is in line with the view of Van Zyl Smit and Snacken, who state that "[t[he European concept of democracy entails that European prison systems and their prison staff must accept criticisms expressed by prisoners".[12] Preventing a hunger striker from expressing his ideas and opinions, even if critical of the authorities involved, is therefore not allowed, especially if this would entail such a drastic measure as force-feeding.

2.5. HUNGER STRIKING IS A FORM OF NON-VIOLENT PROTEST THAT MUST BE TOLERATED

Unlike many other forms of protest within and outside of prisons and other places of detention, hunger striking is a form of non-violent protest. Sevinç deals with hunger strike in terms of "the right to resist", i.e., the right of citizens to rebel against an oppressive government.[13] Although the existence of such a right can be disputed, it is a matter of fact that, in principle, hunger strikers do not hurt or damage anybody with their actions except themselves. A famous hunger strike, already mentioned in the introduction of this book, was that by Mahatma Gandhi (1869-1948), an Indian nationalist leader, who struggled for the independence of India from the British. He employed many forms of non-violent protest to draw attention to this matter, which included several hunger strikes. It can be argued that, as a hunger strike is a form of non-violent protest, there is no ground to intervene in this action by third parties. This argument is frequently pressed by emphasising that, in the outside world, people may freely decide to go on hunger strike and continue their actions without intervention by others. Neither is hunger striking regarded as a criminal act or offence in the outside world. A hunger striker does not resort

11 Ibid., paragraphs 136-145.

12 Van Zyl Smit & Snacken 2008, p. 249.

13 Sevinç 2008, pp. 675-676.

to criminal means to accomplish his ends. In the outside world, States and their authorities almost never get involved in such actions, let alone urge force-feeding. Why would this be different for prisoners and detainees? Tagawa furthermore notes that disallowing hunger strikes may cause prisoners or detainees to resort to more violent, less desirable behaviour to attain their goals.[14]

2.6. FORCE-FEEDING IS A VIOLATION OF THE HUNGER STRIKER'S RIGHT TO HEALTH

The argument that force-feeding is a violation of the prisoners' or detainees' right to health cannot be found in the literature on force-feeding hunger strikers. It was introduced by the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (hereafter: Special Rapporteur on the right to health) in a joint report on the situation of prisoners at the US Naval Base at Guantánamo Bay.[15] I will elaborate on the mandate of the Special Rapporteur on the right to health, this report and its conclusions in Ch. 5, § 2.1.8.

In Ch. 3, § 2.1.1, it was stated that a right to health care for prisoners and detainees can be founded on Article 12 ICESCR. In the section on "The right to the highest attainable standard of physical and mental health", the Special Rapporteur on the right to health and the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (hereafter: Special Rapporteur on torture) looked at the practice of force-feeding prisoners on hunger strike at Guantánamo Bay. The Special Rapporteur on the right to health elaborated on the ethical obligations of health professionals, including in relation to force-feeding, stating that

> "From the perspective of the right to health, informed consent to medical treatment is essential, as is its "logical corollary" the right to refuse treatment [c.f. CESCR, General Comment No. 14 under 8 and 34, see Ch. 3, § 2.1.1]. A competent detainee, no less than any other individual, has the right to refuse treatment. In summary, treating a competent detainee without his or her consent – including force-feeding – is a violation of the right to health, as well as international ethics for health professionals."[16]

The Special Rapporteur on the right to health, together with four other Special Rapporteurs, concluded that the force-feeding of competent prisoners not only violates the ethical duties of any health professionals who may be involved in it, but also the right to health of the hunger striker involved, an opinion that had not been heard before.

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14 Tagawa 1983, p. 590.

15 Situation of Detainees at Guantánamo Bay, UN Doc: E/CN.4?2006/120, (27 February 2006), available at <http://www.unhcr.org/refworld/docid/45377b0b0.html> (last accessed on 25 January 2012).

16 Ibid., p. 27, under 82.

The six arguments in favour of force-feeding that I have outlined above are all mainly based on the belief that prisoners' and detainees' rights and fundamental values should be respected and that they should be protected against forced intervention by third parties. Sometimes, however, arguments advanced against force-feeding are not inspired by the idea of respect for prisoners' and detainees' rights and fundamental values, but by the idea that a fatal outcome of the hunger strike is preferred, as it would be favourable to third parties. Without going into these arguments in depth, I will briefly discuss two of them. The first, rather populist, argument is that non-intervention in the hunger strike is to be preferred, because it would save the State and the prison or the other place of detention the expense of resources required to keep the prisoner or detainee alive, and it would save future costs relating to the deprivation of freedom. The second argument is inspired by victims' interests, emphasizing that victims can feel relieved and maybe even gratified when the sentenced prisoner dies as a result of his hunger strike. Victims therefore may prefer non-intervention above force-feeding.[17] Both of these arguments can be advanced against force-feeding as a way of keeping the hunger striker alive.

3. ARGUMENTS FOR FORCE-FEEDING PRISONERS AND DETAINEES ON HUNGER STRIKE

In the first part of this chapter, I catalogued the arguments that can be put forward against force-feeding. On the basis of these arguments, authorities should abstain from intervention in a hunger strike and respect the hunger striker's wish to continue the hunger strike. However, many arguments can be advanced to overrule a prisoner's or detainee's decision to stop eating and intervene in his hunger strike to prevent him from dying as a result of his action. In the discussion on the use of force-feeding as a method of intervening in a hunger strike, many different arguments in favour of force-feeding can be raised and can carry much weight in the discussion. In the second part of this chapter, I will deal with the arguments that argue for a right to intervention, and argue against an absolute right to die by means of a hunger strike.

3.1. THE STATE'S DUTY TO PROTECT HEALTH AND PRESERVE THE LIFE OF PRISONERS AND DETAINEES

States and their authorities are the only bodies that can lawfully deprive people of their liberty. By doing so, they take on the responsibility to take good care of them. This responsibility entails, among other things, the duty to ensure that prisoners

[17] In § 3.6 of this chapter, I will go into the victims' interests in making sure that the hunger striker lives to stand trial so that justice can be done, as an argument in favour of force-feeding.

and detainees are kept alive and healthy whilst deprived of their liberty. It can be argued that force-feeding hunger-striking prisoners and detainees represents the State's duty to preserve the life of detainees, an imperative that overrides the prisoners' and detainees' rights. The State's duty to preserve the life of detainees is a strong argument both in national debates on the permissibility of the use of force-feeding and in procedures before the ECtHR. From a legal perspective, this is the most important area where conflicts of interests arise. It is a central, if not *the* central argument in favour of force-feeding. I have elaborated on the positive obligations on the basis of Article 2 ECHR in Ch. 3, § 2.2.2. This is reflected in legal procedures before the ECtHR, where the right to intervention of States is mostly founded on the State's duty to preserve the life of the people it has deprived of their liberty on the basis of Article 2 ECHR.

3.2. THE NEED TO CONSTRAIN MANIPULATIVE EFFORTS BY PRISONERS AND DETAINEES

An often heard opinion in arguing in favour of force-feeding is that hunger strikes constitute a manipulative effort and a form of blackmail, and that they therefore should be ended. As already stated in the introduction of this book, hunger strikes are mostly used by people in a powerless position, when they have exhausted all their legal and other possibilities to protest. Hunger strikes put a great deal of pressure on persons or organisations in charge; they are confronted with someone who is prepared to die in order to reach a certain goal. This is especially the case with prisoners and detainees on hunger strike, but also with groups of non-natives on hunger strike, demanding a residence permit or trying to prevent expulsion. A hunger strike can be a powerful instrument, as it places the State and its authorities in a defensive position, and demands direct action from them. The State and its authorities' find themselves in a difficult position, as acceding to the hunger striker's demands would be permitting something which runs counter to their better judgment or existing policy, and would put the hunger striker in a privileged position towards those who follow accepted procedures. If they do not accede to the hunger striker's demands, however, they must experience the dreadfully draining experience of witnessing the hunger striker's slow death. With his hunger strike, the prisoner or detainee forces the State and its authorities into a subordinate position. This subordinate position and the pressure to decide in a certain way can be increased by attention from people and organisations outside the prison or the other place of detention.

To increase the pressure on persons and organisations in charge, hunger strikers (or other persons or organisations surrounding them) often seek attention from the public and media. This can help to create a platform for the hunger striker, to gain sympathy and support for his action and ideas. Attention from the media can be very useful for hunger strikers as it may provide them with a stronger position

in negotiations when public opinion or large groups of people support their strike. Nevertheless, attention from the public may not always be beneficial to the hunger striker, because the extra pressure on the negotiations to succeed or be conducted in a certain way may also lead the negotiations becoming gridlocked. Attention from the public can also cause State authorities to adopt a more rigid attitude and become intransigent towards the hunger striker, as they feel cornered by the attention from the media and public. They can also become more unresponsive towards the hunger striker's demands, as they do not want to lose face in the public eye by meeting the hunger striker's demands. Not all hunger strikers go public with their strike, but even if they do not, authorities may still see the hunger strike as blackmail, especially if the hunger strike is supported by other prisoners and detainees or is performed by larger groups of them.

The feeling of being blackmailed by the hunger striker can lead to several different responses from the authorities.

First, authorities often want to isolate or separate hunger strikers in order to prevent other prisoners and detainees from following their example. Isolation or separation from other prisoners or detainees may also be urged because, as shown above, attention from the media and public may benefit the hunger striker's action. Isolation or separation also makes it easier for authorities to disregard the hunger striker's actions, as they take away the opportunity for the hunger striker to demand attention for his situation. Isolation or separation of hunger strikers is not always motivated by the feeling of being blackmailed but can also be for medical reasons, for example, to monitor the hunger striker's intake of food and water.[18]

Secondly, the feeling of being blackmailed by the hunger strike can form a strong argument for intervention through the use of force-feeding, because authorities fear the bad publicity arising from a prolonged hunger strike or because the force-feeding suppresses the power of the hunger striker to intentionally starve himself. It could even be argued that, for this reason, force-feeding must start at the same time as, or shortly after, the beginning of the hunger strike. Such a harsh imposition of power through the use of force-feeding can be demonstrated with examples from the English suffragettes in the early twentieth century.[19] In doing so, the hunger striker's possibility to manipulate is completely removed.

Finally, although mostly used as an argument to make a case for force-feeding, the need to constrain manipulative efforts by prisoners and detainees can also cause authorities to completely *abstain* from any intervention in the hunger strike. If they completely ignore the action (as with isolation), the prisoner or detainee will not (or will no longer) be able to draw attention to his strike. It will make him and his action powerless. Ignoring a hunger strike demonstrates a refusal to engage with hunger strikers in the matter under dispute. Such a policy can be used as a way to

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[18] In Ch. 7, § 3, I will pay attention to the issue of isolating and separating hunger strikers.

[19] See Ch. 6, § 4 where the history of the policy on hunger strikes in England and Wales is discussed.

dispirit present hunger strikers and to discourage other prisoners and detainees from using hunger strikes as a means of protest in the future. The need to thwart manipulative efforts by prisoners and detainees is not only a relevant factor in formulating policy on hunger strikes within countries, but is often also a relevant factor in political debates on force-feeding.

3.3. PRESERVING INTERNAL ORDER, SECURITY AND DISCIPLINE WITHIN THE PRISON OR OTHER PLACE OF DETENTION

It is in the State's interests to ensure good order in prisons and other places of detention. As shown above, hunger strikes often cause a great deal of turmoil, both within and outside the prison or the other place of detention. Hunger strikes can greatly disturb the internal order and security of the prison or the other place of detention. This is especially the case when larger groups of people participate in the hunger strike. Massive hunger strikes can be employed as a direct means of protest against the custodial authorities. This was the case in the two lethal hunger strikes I mentioned in Chapter 1; the hunger strike of the IRA prisoners in the HM Maze Prison in Northern Ireland in 1980 and 1981, and the massive Turkish hunger strike from 2000 to 2003. In both cases, the internal order was severely disturbed by the hunger strikes.

Not only groups, but also individuals may draw a great deal of attention, especially if the hunger strike is prolonged and the hunger striker is likely to die as a result of his action. Death of a hunger striker can incite riots within and outside the prison or other place of detention. A hunger strike not only causes turmoil and distress among the other prisoners and detainees, but arouses the same feelings among the people working in prison or the other place of detention. It can be argued that even individual hunger strikes should be ended to preserve the internal order, security and discipline within a prison or other place of detention. Although in the US "effective prison administration", which includes maintaining institutional security and preserving internal order and discipline, can serve as a justification for force-feeding,[20] the argument of preserving internal order and discipline almost never occurs as a leading argument in European discussions on the legitimacy of force-feeding. However, in practice, preserving internal order, security and discipline is a principal task for the custodial authorities, which will also have repercussions on the treatment of hunger strikers.

As shown above, force-feeding can be used as a tool to rigorously enforce control within the place of detention and suppress resistance by prisoners and detainees. By force-feeding protesting prisoners or detainees, authorities show that disruptive

[20] Silver 2005, p. 648.

behaviour will not be tolerated. This was, *inter alia*, the case with hunger striking prisoners on the US Naval Base at Guantánamo Bay who were immediately force-fed when they began a hunger strike. In general, force-feeding may serve as a symbolic measure. It can also be used as a way to punish the individual hunger striker for his "insubordinate conduct". Force-feeding, in this way, can be a powerful tool for totalitarian regimes to enforce and preserve internal custodial order and discipline.

3.4. HUNGER STRIKE IS A FORM OF SUICIDE AND SHOULD THEREFORE BE PREVENTED

On the basis of Article 2 ECHR, States and their authorities are under a duty to preserve the life of prisoners and detainees. The cases of *Keenan* and *Renolde* (see Ch. 3, § 5) show that the authorities of the prison or the other place of detention are under an obligation to take adequate measures to prevent suicides. The CPT has also stressed the importance of suicide prevention in prisons and other places of detention, in, *inter alia*, determining that the health care services in prisons or other places of detention should ensure both general awareness of this issue, and the implementation of appropriate procedures.[21] Intervention in hunger strikes through force-feeding can be justified if hunger strikes are considered to be a form of suicide. In Ch. 1, § 3, I showed, however, that a hunger strike differs significantly from suicide. The aim of suicide is death, but death is not the desired outcome for a hunger striker; he has the hopes that his demands will be met and he can start eating again. In this way, risking death is a means to an end. Hunger strikers do not intend to die; they want to live. However, there will be a group of prisoners or detainees who go on hunger strike as a way to commit suicide. According to the ECtHR, if information indicates that a prisoner or detainee poses a real and immediate risk of suicide, State authorities have to take appropriate steps to protect his life. In such cases, it is the State's duty to take reasonable care to prevent the prisoner or detainee from engaging in such an act.

3.5. THE PREVENTION OF MARTYRDOM

The fifth argument that can be put forward, the prevention of martyrdom, is not often publicly illustrated in discussions on the use of force-feeding. However, it plays an important role in hunger strikes that are politically motivated. History shows that a hunger strike can be an important means for leading figures of resistance movements to further their political cause. A remarkable hunger strike in this

[21] The CPT Standards. "Substantive" sections of the CPT's General Reports, Council of Europe, CPT/Inf/E (2002) 1 – Rev. 2010. Available at <http://www.cpt.coe.int/EN/docsstandards.htm> (last accessed on 16 January 2012), p. 33, under 57-59.

respect is that of Irish Republican political Bobby Sands, who died as a result of his hunger strike in 1981 (see Ch. 6, § 4.5). His portrait still features prominently in prisons throughout Northern Ireland, and he is still considered to be one of the most important champions in the struggle for autonomy for Northern Ireland. Another remarkable case in this respect is that of Iñaki de Juana Chaos in Spain. Although he did not die as a result of his hunger strike, it was front-page news for months and caused much turmoil and chaos inside and outside Spain. Thousands of people supported the ETA leader in his actions and over 600 other ETA prisoners and detainees followed his actions closely, many of whom also went on hunger strike.[22] Iñaki de Juana Chaos' hunger strike was a highly political one, as the eyes of the world focused on the Spanish-Basque situation. In this case, the stakes for the Spanish authorities were high – to prevent Iñaki de Juana Chaos from dying and, in this way, becoming a martyr for current and future supporters of the ETA movement. His prolonged hunger strike had already led to the image of the hunger striker as a martyr, suffering for those struggling for Basque autonomy. His death would probably have led to his glorification, and many others would have followed his example. Force-feeding in this case was urged to prevent the hunger striker from taking his own life and becoming a martyr as a result. The death of the hunger striker could also aggravate a tense or sensitive political situation in a country. Together with the need to limit manipulative efforts by prisoners and detainees, the argument that martyrdom should be prevented is most important in political debates on intervention in hunger strikes that are politically motivated. Still, it must be noted that the application of force-feeding can also add to the glorification of the hunger striker, as it clearly shows the resistance that is undermined by the State and its authorities.

3.6. MAKING SURE THAT THE HUNGER STRIKER LIVES TO STAND TRIAL SO THAT JUSTICE CAN BE DONE

As shown in Ch. 1, § 5, a hunger strike can become fatal after a period of 40 days. If the hunger striker dies, he will not or would no longer be able to stand trial, as trials end when the accused dies. For victims or other interested parties it is often very important that the hunger striker lives to stand trial, so that justice can run its course. Trials can be very important for victims as a means to obtain redress, as a way to find closure, to get a definite answer on what exactly happened, and to determine the criminal responsibility of those indicted, be it through acquittal or conviction. This possibility is taken away if the hunger striker is permitted to starve himself whilst in pre-trial detention.

[22] Oñorbe Genovesi 2007.

The death of the hunger striker before a trial takes places are not only painful to those who are directly involved in the criminal case, it can also cause a great a deal of commotion among groups of people in society. This especially applies to suspects who are awaiting trial before international war crimes tribunals, such as the International Criminal Tribunal for the former Yugoslavia (hereafter: ICTY), courts that have been especially set up to investigate and prosecute offenders of serious crimes against humanity. These trials are often very important for (groups of) victims and their next of kin to obtain reparation for the suffering inflicted. Force-feeding can be urged in such cases to prevent the hunger striker from taking his life before the trial takes places.

Such was the case with the hunger strike of Vojislav Šešelj (see also Ch. 5, § 2.1.9). During his hunger strike in 2006 his health became endangered after he had refused to eat for 27 days. As a result, the ICTY in The Hague ordered the Dutch authorities to force-feed him if necessary to stop him dying from his hunger strike. In a statement, the ICTY said that "[t]he Trial Chamber is concerned that a situation might arise where the Accused's right to physical integrity and the obligation of the Tribunal to protect the Accused's health and welfare are in conflict". Force-feeding was urged because "[u]nder the present circumstances, the Trial Chamber finds that there is a prevailing interest in continuing with the trial of the Accused in order to serve the ends of justice. The trial […] should not be undermined by the Accused's manipulative behavior."[23] This last remark again shows the close interconnection between the different arguments in favour of force-feeding.

Making sure that the hunger striker lives to stand trial so that justice can be done can be a strong argument in favour of force-feeding. Not only can victims' interests play a role, public opinion can also create a great deal of pressure on the authorities in charge to preserve the life of the hunger striker. A clear example of this is the hunger strike of Volkert van der G. in the Netherlands in 2002. On 6 May 2002, Volkert van der G. assassinated Pim Fortuyn, a well-known Dutch politician and the first candidate on the list of the LPF party for the imminent parliamentary elections on 15 May 2002. This killing attracted massive national and international publicity; many perceived his killing as a direct attack on democracy. Whilst in pre-trial detention, the accused went on hunger strike. The question was raised whether Van der G. could be force-fed to prevent him from dying, a question that became more urgent as the hunger strike continued. Politicians voiced the opinion that Van der G. should be force-fed if his situation became life-threatening, to make sure that he would be able to stand trial. The death of the Van der G. before justice could be done would cause much turmoil within society and politics. Finally, Van der

[23] *Urgent Order to the Dutch Authorities Regarding Health and Welfare of the Accused*. ICTY Trial Chamber, 6 December 2009, pp. 4-5.

G. stopped his hunger strike of his own accord after 70 days, without intervention from third parties.[24]

Societal and victims' interests to preserve the life of the hunger striker not only play a role before a trial takes place, but also if a prisoner goes on hunger strike in prison *after* sentencing. Death as a result of a hunger strike can be a method of "escaping punishment". Force-feeding can then be urged to prevent the prisoner from starving himself to "avoid" serving his sentence in full. As Wilson formulated it: "it is [the prison authorities'] duty to see that a prison sentence is completed, and force may obviously be necessary to prevent a prisoner escaping, either to the outside world or to the next, this obligation".[25] Permitting a prisoner or detainee to die as a result of a hunger strike would enable him to avoid to fully serve the punishment that society has deemed appropriate.

3.7. GATHERING INFORMATION FROM THE SUSPECT IN PRE-TRIAL DETENTION

Another argument in favour of force-feeding during pre-trial detention is that it may prevent the hunger striker from dying, and information on his alleged offence from being lost. The suspect in pre-trial detention is often the only person with useful knowledge on past or planned criminal activities, motives and the full facts of the case, which is valuable information for criminal investigation and prosecution. In these cases, the question arises as to whether force-feeding can be justified with regard to the *nemo tenetur* principle, the defendant's right to remain silent and the privilege against self-incrimination.

The *nemo tenetur* principle prohibits forced self-incrimination. The "right to remain silent" and the "right not to incriminate oneself" are legally enshrined in Article 6 ECHR, on the right to a fair trial. This was first acknowledged by the ECtHR in the case of *Funke* in 1993.[26] Since then, the ECtHR has given its opinion on the issue in several cases. Below, I will summarise the general scope of European case law on this topic.[27]

In the case of *John Murray*, the Grand Chamber of the ECtHR reiterated that

> "Although not specifically mentioned in Article 6 […] of the Convention, there can be no doubt that the right to remain silent under police questioning and the privilege against self-incrimination are generally recognised international standards which lie at the heart of the notion of a fair procedure under Article 6 […]. By providing

[24] I will elaborate on the case of Volkert van der G. in Ch. 6, § 2.8.

[25] David Wilson, *The Sunday Times*, 16 June 1974. As cited by Zellick 1976, p. 175.

[26] ECtHR 25 February 1993, *Funke v France,* App. No. 10828/84.

[27] For a more in-depth study and references, see Stevens 2005.

> the accused with protection against improper compulsion by the authorities these immunities contribute to avoiding miscarriages of justice and to securing the aims of Article 6 […]."[28]

The ECtHR thus acknowledges that the right to remain silent under police questioning and the privilege against self-incrimination constitute two important parts of the right to a fair trial as contained in Article 6 ECHR.[29] The right to remain silent, according to the ECtHR, in principle serves to protect the freedom of a suspected person to choose whether to speak or to remain silent when questioned by the police.

> "Such freedom of choice is effectively undermined in a case in which, the suspect having elected to remain silent during questioning, the authorities use subterfuge to elicit, from the suspect, confessions or other statements of an incriminatory nature, which they were unable to obtain during such questioning and where the confessions or statements thereby obtained are adduced in evidence at trial."

Whether the right to remain silent is undermined to such an extent as to give rise to a violation of Article 6 ECHR depends on the circumstances of the individual case.[30] The right to remain silent is not absolute.[31] The ECtHR has consistently held that the right not to incriminate oneself is primarily concerned with respecting the will of an accused person to remain silent in the context of criminal proceedings and with the use made of compulsorily obtained information in criminal proceedings. In, *inter alia*, the case of *Saunders* the Grand Chamber of the ECtHR stated that "[t]he right not to incriminate oneself, in particular, presupposes that the prosecution in a criminal case seek to prove their case against the accused without resort to evidence obtained through methods of coercion or oppression in defiance of the will of the accused".[32] The right not to incriminate oneself does not extend, however, to the use in criminal proceedings of material which may be obtained from the accused through the use of compulsory powers but which has an existence independent of the will of the suspect such as, *inter alia*, documents acquired pursuant to a warrant, breath, blood, urine, hair and voice samples and bodily tissue for the purpose of DNA testing.[33] In the case of *Jalloh*, the Grand Chamber of the ECtHR added that

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28 ECtHR 8 February 1996, *John Murray v the United Kingdom* (Grand Chamber), App. No. 18731/91, paragraph 45.

29 The ECtHR is not clear on all points on the content of the right to remain silent, the privilege against self-incrimination and their relationship. See Stevens 2005, p. 9 ff.

30 ECtHR 5 November 2002, *Allan v the United Kingdom,* App. No. 48539/99, paragraphs 50 and 51.

31 See, for example, ECtHR 8 February 1996, *John Murray v the United Kingdom,* App. No. 18731/91.

32 ECtHR 17 December 1996, *Saunders v the United Kingdom,* App. No. 19187/91 (Grand Chamber), paragraph 68.

33 ECtHR 17 December 1996, *Saunders v the United Kingdom,* App. No. 19187/91 (Grand Chamber), paragraph 69. Also ECtHR 5 November 2002, *Allan v the United Kingdom,* App. No. 48539/99,

in examining whether a procedure violates the privilege against self-incrimination, the ECtHR will consider the following elements: the nature and degree of the compulsion and the existence of any relevant safeguards in the procedures and the use to which any material so obtained is put.[34]

3.8. INTERESTS OF DEPENDENT THIRD PARTIES

Hunger strikers are sometimes responsible for third parties, such as children, handicapped, or elderly people who are under their care. The argument that interests of dependent third parties may overrule the prisoner's or detainee's decision to hunger strike is sometimes advanced in US case law and literature on force-feeding. The argument, mostly phrased as "the protection of innocent third parties" refers principally to dependants (mostly children) of the hunger striker who could be negatively affected by the harmful outcome of the hunger strike, emotionally or financially. Prisoners or detainees with children rarely go on hunger strike, and this interest has only been little recognised by the US courts.[35] This argument hardly plays any role in European discussions on force-feeding.

3.9. THE HUNGER STRIKER'S OWN INTEREST IN PRESERVING HIS HEALTH AND LIFE

In general, when the question of force-feeding arises, the prisoner's or detainee's rights and other parties' interests collide. The arguments that were outlined above summarise third parties' interests that can be put forward in favour of force-feeding. Not only third parties' interests can play a role, but also the hunger striker's own interest in preserving his health and life. Force-feeding can be applied to protect him from the harmful mental and physical consequences of the hunger strike. The argument that the hunger striker must be protected from himself by the use of force-feeding reflects the paternalist approach. On the basis of this approach, it can be argued that, although it is against his will, the hunger striker should be forcibly fed because he will be better off when protected from the harm that he is inflicting upon himself. As also noted in Ch. 2, § 5, persons can only act in a paternalistic way towards another person if the person whose decisions are overruled is competent

paragraph 44, ECtHR 11 July 2006, *Jalloh v Germany* (Grand Chamber), App. No. 54810/00 (Grand Chamber), paragraphs 94-117, ECtHR 29 June *2007, O'Halloran and Francis v the United Kingdom* (Grand Chamber), App. Nos. 15809/02 and 25624/02, paragraphs 53-63, and ECtHR 23 March 2006, *Van Vondel v the Netherland,* (decision), App. No. 38258/03.

34 ECtHR 11 July 2006, *Jalloh v Germany* (Grand Chamber), App. No. 54810/00, paragraph 101.

35 Welsh 2009, p. 146 and Silver 2005. Tagawa has also elaborated on this issue: Tagawa 1983, pp. 591-595.

to decide otherwise. Incompetence implies that a person is not capable of deciding for himself and that decision-making authority is delegated to another person or organisation.

Force-feeding can also be urged by parties surrounding the hunger striker as a means of giving the hunger striker time to rethink his decision. Often, hunger strikers are not aware of the serious physical and mental consequences of a hunger strike, also in the long term. Force-feeding can then give others, such as family members and friends, time to persuade the hunger striker to end his action. A decision to starve oneself to death, made by otherwise perfectly healthy people, is foolish in the eyes of many. Advocates of this approach emphasise that there have been cases where a force-fed hunger striker has expressed his relief at being alive. Still, it should be noted that in most cases, force-feeding will only be medically necessary after a prolonged period of hunger striking. It is most likely that the hunger striker will have enough time to rethink his decision during this period. The argument that force-feeding must be applied to give the hunger striker time to rethink his decision can therefore often be considered an expression of a strong paternalistic approach towards the hunger striker.

In the second part of this chapter I gave an overview of nine main arguments in arguing in favour of force-feeding. It should be mentioned that, although not listed as a separate argument in this chapter, religious beliefs can also play a role in arguing in favour of force-feeding. Some religions prioritise saving the life of the hunger striker over the personal autonomy of the person who is refusing food. Some religious beliefs strongly emphasise the importance and the sanctity of life and argue that decisions concerning life and death may not be made by individuals for their own benefit.[36] The personal religious beliefs of the physician involved may also strongly influence his decision on whether to allow the hunger striker to die or to intervene against his wishes to preserve his life. In my opinion, religious beliefs do not constitute a separate argument in arguing for or against force-feeding, but may strongly influence opinions on the overall balance of the different arguments *pro* and *con*.

4. CONCLUSIONS

If a prisoner or detainee goes on hunger strike and a decision must be made on whether to force-feed him, the question is whether the rights of the hunger striker or the rights and duties of other parties concerned should prevail. The various arguments put forward in weighing these rights and duties were listed in this

[36] See, for example, the impressive and more than 17-minute-long ethical and religious discussion on hunger strike between the IRA hunger striker Bobby Sands (played by Michael Fassbender) and a Catholic priest (played by Liam Cunningham) in the movie *Hunger* (2008), directed by Steve McQueen.

chapter. This overview shows that there are interests of a medical-ethical, legal, societal and political nature that all play a role in the discussion on the legitimacy of force-feeding. Arguments against force-feeding prisoners and detainees on hunger strike are: force-feeding infringes upon the prisoner's or detainee's right to self-determination; force-feeding is a form of torture or inhuman or degrading treatment or punishment; force-feeding contravenes medical ethics; force-feeding is a violation of the hunger striker's freedom of expression; hunger striking is a form of non-violent protest that must be tolerated; and force-feeding is a violation of the prisoner's or detainee's right to health. All these arguments underline the view that hunger strikers should be free to begin and continue their strike without intervention from third parties. Arguments in favour of force-feeding prisoners and detainees on the hunger strike are: the State's duty to protect health and preserve the life of prisoners and detainees; the need to constrain manipulative efforts by prisoners and detainees; preserving internal order, security and discipline within the prison or other place of detention; hunger strike is a form of suicide and should therefore be prevented; the prevention of martyrdom; making sure that the hunger striker lives to stand trial so that justice can be done; information from the suspect in pre-trial detention must be gathered; and the hunger striker's health and life must be preserved with regard to the hunger striker's own interest, and the interests of dependent third parties. All these arguments underline the view that other parties' interests, or the prisoner's or detainee's own best interests, can justify intervention in the hunger strike to save his life.

In the next chapter, I will investigate how European and international documents go about this matter, how they balance these different interests, and what arguments are considered to be decisive in determining whether force-feeding prisoners and detainees on hunger strike can be justified, and if so, under what circumstances.

CHAPTER FIVE

INTERNATIONAL AND EUROPEAN DOCUMENTS AND CASE LAW ON FORCE-FEEDING PRISONERS AND DETAINEES ON HUNGER STRIKE

1. INTRODUCTION

In the previous chapter, I listed all the arguments that can be raised for and against force-feeding prisoners and detainees on hunger strike. In this chapter, I will investigate how these pros and cons are assessed in international and European documents. I will elaborate on the international and European documents that are entirely or partly concerned with the issue of force-feeding prisoners and detainees on hunger strike. Only few documents, such as the WMA Declaration of Malta, are entirely devoted to the issue of force-feeding. In other documents, provisions can be found that, for instance, concern the regulation of force within prison or other place of detention, the instruments of restraint, or the possibilities for forced medical treatment, issues that indirectly concern the issue of force-feeding. As will become clear, some of these documents aim to provide guidance to physicians and other health staff for medical-ethical behaviour in hunger strikes. In prolonged hunger strikes in particular, these physicians are faced with difficult dilemmas. Besides the issue of dual loyalties (the conflict between the physician's loyalty to the employing authority (such as the custodial board) and the loyalty to his patients), as elaborated on in Ch. 3, § 3, physicians in prolonged hunger strikes are confronted with the tension between, on the one hand, the need to preserve life and, on the other hand, respect for the autonomy of the individual. Several documents on an international level address these dilemmas and questions. In addition, several human rights documents, but especially human rights mechanisms such as the ECtHR, have devoted themselves to this issue and have set guidelines for the assessment of force-feeding from a legal perspective.

In this chapter, I will first go into the international documents and case law that relate to this topic. Secondly, I will explore the European legal framework that is,

inter alia, formed by the ECHR and case law of the EComHR and the ECtHR on force-feeding prisoners and detainees on hunger strike. Fourthly, I will go into the analysis of force-feeding by different NGOs. Fifthly and finally, I will offer conclusions.

2. INTERNATIONAL DOCUMENTS AND CASE LAW ON FORCE-FEEDING PRISONERS AND DETAINEES ON HUNGER STRIKE

Numerous international human rights treaties and other types of instruments, such as declarations, recommendations and bodies of principles, touch on the human rights of prisoners and detainees. These instruments vary in legal status and binding effect (see Ch. 3, § 2.1). In this chapter, for each instrument discussed I will indicate its legal status and its binding effect.

In Ch. 3, § 2.1, I elaborated on standards concerning health care in prisons and other places of detention as codified in these international and European documents. On an international level, several organisations have issued documents that directly or indirectly concern the issue of force-feeding prisoners and detainees on hunger strike. Below, I will discuss relevant materials issued by the UN and relevant cases before UN human rights mechanisms.

2.1. THE UN

The UN agreements on human rights described in In Ch. 3, § 2.1.1, such as the SMR, the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment of 1988, and the Basic Principles for the Treatment of Prisoners of 1990 provide standards and safeguards for the protection of the rights of prisoners and detainees. These documents underline the need for the protection of prisoners' and detainees' human rights and their human dignity. Several of the UN agreements contain stipulations that are relevant for the issue of force-feeding. Below, I will go into these relevant stipulations, as laid down in the Principles of Medical Ethics, the SMR and the Geneva Conventions.

2.1.1. Principles of Medical Ethics[1]

In 1982, the Resolution on the Principles of Medical Ethics was adopted by the General Assembly. This instrument has no binding legal effect, and can qualify as

[1] UN Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees against Torture, and Other Cruel, Inhuman or Degrading Treatment or Punishment, UN Doc A/37/51, 1982.

soft law. The document, although focusing on the role of the physician, gives ethical guidelines for all health personnel, and is also applicable to, for example, nurses.

As stated in Ch. 3, § 2.1.1, this document applies to all persons who are deprived of their liberty as illustrated in the SMR, as it not only refers to prisoners; its title and text refer to both prisoners and detainees. In Principle 1, the equivalence of care principle for prisoners and detainees is formulated.[2] In Principle 2, it is furthermore stated that "[i]t is a gross contravention of medical ethics, as well as an offence under applicable international instruments, for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading punishment". Health personnel, especially physicians, may not be involved in acts of torture or other cruel inhuman or degrading treatment. The fourth and fifth Principles contain basic rules for the involvement of health personnel in interrogations (Principle 4), and restraining prisoners and detainees (Principle 5). In Principle 4, it is stated that health personnel may not be involved in interrogation of prisoners and detainees in a manner that may adversely affect their mental health. Under Principle 5, it is stated that

> "[i]t is a contravention of medical ethics for health personnel, particularly physicians, to participate in any procedure for restraining a prisoner or detainee unless such a procedure is determined in accordance with purely medical criteria as being necessary for the protection of the physical or mental health or the safety of the prisoner or detainee himself, of his fellow prisoners or detainees, or of his guardians, and it presents no hazard to his physical or mental health."

On the basis of this Principle, physician complicity in restraining prisoners or detainees is not allowed, unless it is medically necessary and presents no hazard to his physical or mental health. This Principle underlines the need to work in the interest of the prisoner or detainee involved. Also, the last sentence of the Principle ("and it presents no hazard to his physical or mental health") requires that a procedure for restraining may not cause the prisoner or detainee more harm than it does good; it is a demand for proportionality. As has been shown in Ch. 1, § 8.3, if the hunger striker is conscious and non-cooperative, he will always have to be physically restrained or anaesthetised to prevent him from resisting when the tube or the catheter is inserted, and from removing it afterwards. According to this principle, this restraint may only be applied on the basis of purely medical criteria if necessary for the protection of the physical or mental health of the hunger striker and if it presents no hazard to his physical or mental health. In my view, short-term restraining of a prisoner or detainee on hunger strike, under these conditions – although certainly not pleasant for the person involved – presents no

[2] For an elaboration on this topic, see Ch. 3, § 2.1.2.

hazard to his physical or mental health and is thus allowed according to Principle 5. Still, the application of this Principle to the issue of force-feeding is problematic, as the Article's scope is unclear and it is formulated in very general terms. Principle 5 seems to have been overtaken by the more recent WMA Declaration of Malta (see Ch. 5, § 2.2.2) which is entirely dedicated to the issue of medical-ethical behaviour of physicians involved in the treatment of prisoners and detainees on hunger strike.

2.1.2. The SMR[3]

As already stated in Ch. 3, § 2.1.1, the SMR provide a set of standards and safeguards for the protection of the rights of prisoners and detainees. Although the SMR have no legally binding effect, they set out what is generally accepted as good principle and practice in the treatment of prisoners and the management of prison institutions (see under Principle 1).

The SMR do not contain explicit stipulations concerning force-feeding. Rules 33 and 34, however, contain stipulations concerning instruments of restraint. As stated above, force-feeding always requires the use of restraint, unless the hunger striker is sedated or is already in a coma. Rule 33 provides that instruments of restraint, such as handcuffs, chains, irons and strait-jackets, may never be applied as a punishment. It furthermore states that chains and irons may not be used as restraints. According to Rule 34, other instruments of restraint may not be used either, except a) to prevent escape during a transfer, b) on medical grounds by direction of the medical officer, or c) by order of the director, if other methods of control fail, in order to prevent a prisoner from injuring himself or others or from damaging property. In the latter case, the director must consult the medical officer and report to the higher administrative authority. Rule 34 adds that the patterns and manner of use of the instruments of restraint shall be decided by the central prison administration. Also, such instruments may not be applied for any longer than is strictly necessary.

According to the SMR, instruments of restraint may not be used as a punishment. This also applies for hunger strikers. Still, it provides that instruments of restraints may be used on medical grounds by direction of the medical officer. The exception as laid down in Rule 34 under b) can be used to justify the force that is necessary to feed the hunger striker. It can also be argued that force may be used to prevent a prisoner from injuring himself, as described under c), although this stipulation in my view is more concerned with protecting suicidal prisoners or detainees against themselves and, as I demonstrated in Ch. 1, § 3, hunger strikers are not suicidal.

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[3] Standard Minimum Rules for the Treatment of Prisoners. Adopted by the First UN Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its Resolution 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977.

2.1.3. The Geneva Conventions[4]

As shown above, the Principles of Medical Ethics prohibit health personnel, particularly physicians, from engaging in torture or other cruel, inhuman or degrading treatment. A couple of years after the adoption of this document, the UN drafted the Convention against Torture, which bans torture under all circumstances.[5] Article 2 of the Convention against Torture states: "No exceptional circumstances whatsoever, whether a state of war or a threat or war, internal political instability or any other public emergency, may be invoked as a justification of torture." Accordingly, the right to be free from torture and cruel, inhuman or degrading treatment or punishment is non-derogable, and no circumstances may be invoked to justify derogation.

The Convention against Torture not only defines torture, but also contains measures to be taken by States Parties to prevent acts of torture and other cruel, inhuman or degrading treatment or punishment. Articles 10 and 11 contain specific stipulations to prevent torture from occurring in prisons and other places of detention. The right not to be subjected to torture or cruel, inhuman or degrading treatment or punishment is also explicitly affirmed in Article 7 ICCPR. Moreover, it can be argued that the prohibition of torture and cruel, inhuman, or degrading treatment is part of *ius cogens*, and it should therefore be respected at all times. Although the UN has issued documents that specifically concern human rights standards for persons in prisons and other places of detention, such as the SMR, the more general international standards on the prohibition of torture also remain relevant for persons in custody. These general documents, however, often play no major role in legal procedures on such specific matters as force-feeding because of their very general wording and lack of direct effect and legal binding force. This is different for the Geneva Conventions of 1949 of which common Article 3 has played a significant role in the discussion on the US policy of force-feeding hunger strikers at Guantánamo Bay. The Geneva Conventions form an important source of international humanitarian law; i.e. the subset of human rights applicable in times of armed conflict. The Geneva Conventions are legally binding for those States that ratify or accede to them, such as the US.[6] Still, from case law of the International Court of Justice it can be concluded that the Geneva Conventions have become part of international humanitarian law and bind all States, whether or not they

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4 Convention (III) relative to the Treatment of Prisoners of War, Geneva, 12 August 1949.

5 UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment Adopted by General Assembly Resolution 39/46 of 10 December 1984, entry into force 26 June 1987. UN Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, 1988, under Principle 6.

6 At the time of writing (January 2012), the four Geneva Conventions have 194 States Parties.

had ratified them, as their principles constitute "intransgressible principles of international customary law".[7]

The Geneva Conventions of 1949 were originally designed to regulate the conduct of armed conflict and sought to limit its effects. The third Geneva Convention of 1949 requires the humane treatment of prisoners of war. The definition of prisoners of war, in the sense of the Convention, encompasses a wide group of prisoners as described in Article 4. Article 3, common to the four Geneva Conventions, establishes fundamental rules from which no derogation is permitted. It is often called "a mini-Convention within the Conventions", as it contains the essence of the Geneva Conventions, and makes them applicable to conflicts that are not of an international character.[8] Common Article 3 requires that all prisoners should be "treated humanely", and prohibits "cruel treatment and torture, and "outrages upon personal dignity, in particular, humiliating and degrading treatment" (under paragraph 1, a) and c)). Since 2006, on the US Naval Base at Guantánamo Bay in Cuba a great number of prisoners were force-fed while on hunger strike. Use was made of an "emergency restraint chair": a chair in which prisoners were strapped up in six-point restraints, including the head and torso. The force-feeding was applied by military physicians, many of whom had signed a declaration beforehand that they would cooperate in these practices. Lawyers, physicians and human rights organisations fiercely protested against this practice of force-feeding for military or political purposes or as punishment, *inter alia*, referring to common Article 3 of the Geneva Conventions.[9]

2.1.4. UN human rights review mechanisms

As shown above, the UN touches upon the issue of prisoners and detainees only briefly in its documents. It is therefore interesting to determine whether the UN human rights review mechanisms have gone into this issue. To this end, I have examined documents of the CESCR, the Human Rights Committee, the CAT, the Special Rapporteur on the right to health, the Special Rapporteur on torture and the ICTY. For a correct understanding of each of these human rights review mechanisms, I will first explore their task and mandate before discussing their view on force-feeding prisoners and detainees on hunger strike.

In this respect, it is important to note that the case law of all three monitoring bodies as discussed below are non-binding upon States (not even upon the parties to them); they are not courts with the power of binding decisions on the merits

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7 E.g. in its advisory opinion on the *Legality of the Threat or Use of Nuclear Weapons*, I.C.J. Reports 1996, p. 226, as noted by Shaw 2008, pp. 1170 and 1187.

8 <http://www.icrc.org/web/eng/siteeng0.nsf/html/genevaconventions> (last accessed on 17 January 2012).

9 See, among many others, Welsh 2009 and Annas 2006.

of the case (such as the ECtHR, for instance). Furthermore, these monitoring bodies consist not only of lawyers, and their judgments are often very categorical and pragmatic. Moreover, unlike the judgments of the ECtHR, their judgments are not intended to create legal precedent. This makes it difficult to draw general conclusions from their statements.

2.1.5. The CESCR

The CESCR is the body of independent experts that monitors implementation of the ICESCR by its States Parties. All States Parties are obliged to submit regular reports to the CESCR on how the rights are being implemented. States must report initially within two years of accepting the ICESCR and thereafter every five years. The CESCR examines each report and addresses its concerns and recommendations to the State Party in the form of Concluding Observations. In December 2008, the General Assembly adopted an Optional Protocol to receive and consider individual complaints.[10] The CESCR also publishes its interpretation of the provisions of the ICESCR, known as General Comments.[11] It should be noted that unlike, for example, the Human Rights Committee, the CESCR is not autonomous, and it is not responsible to the States Parties but to a main organ of the UN. The case law of the CESCR is not binding, and it has only relatively weak means of implementation at its disposal.[12]

As stated in Ch. 3, § 2.1.1 and Ch. 4, § 2.6, the CESCR acknowledges in General Comment No. 14 on Article 12 that the right to health contains both freedoms and entitlements, the former including the right to control one's health and body and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. In General Comment No. 14, the CESCR defines the legal obligations that States Parties have to fulfil in order to ensure the right to health at the national level. This legal obligation includes, *inter alia*, to refrain from denying or limiting equal access for all persons, including prisoners and detainees, minorities, asylum seekers and illegal immigrants.[13] Besides these more general notions, the CESCR's Concluding Observations and General Comments do not contain stipulations concerning the specific issue of prisoners and detainees on hunger strike.

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10 GA Resolution A/RES/63/117.

11 <http://www2.ohchr.org/english/bodies/cescr/> (last accessed on 17 January 2012).

12 Shaw 2008, p. 309.

13 Substantive issues arising in the implementation of the ICESC, General Comment No. 14, E/C.12/2000/4, under 8 and 34.

2.1.6. The Human Rights Committee

As already stated in Ch. 3, § 2.1.1, the Human Rights Committee is the body of independent experts that monitors implementation of the ICCPR by its States Parties. States Parties are obliged to submit regular reports to the Human Rights Committee on how the rights as laid down in the ICCPR are implemented. They must report initially one year after acceding to the ICCPR, and then whenever the Committee requests (usually every four years). The Committee examines each report and addresses its concerns and recommendations to the State Party in the form of "Concluding Observations". The Human Rights Committee also hears inter-State complaints and individual complaints with regard to alleged violations of the ICCPR by States Parties. The Human Rights Committee publishes its interpretation of the content of human rights provisions in its General Comments.[14] In Article 2 of the ICCPR it is stated that every State Party must undertake "to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant". As already stated in Ch. 3, § 2.1.1, the Human Rights Committee has ruled that "persons deprived of their liberty must not be subjected to any hardship or constraint other than that resulting from the deprivation of liberty; respect for the dignity of such persons must be guaranteed under the same conditions as for that of free persons", and added that "by arresting and detaining individuals [States Parties] take the responsibility to care for their life".[15] A lack of financial means does not reduce this responsibility.[16]

In 2007, in its Concluding Observations on a periodic report submitted by Austria, the Human Rights Committee observed and noted with concern that, under Section 79 (6) of the Austrian Aliens Police Act, detainees awaiting deportation who are on hunger strike could be kept in detention which reportedly might result in situations where their life or health was endangered, in the absence of adequate medical supervision. It was particularly concerned about an 18 year-old asylum seeker from Gambia and a Nigerian detainee awaiting deportation who died after 11 and 41 days of hunger striking respectively. In response to this, the Human Rights Committee noted that "[t]he State party should ensure adequate medical supervision and treatment of detainees awaiting deportation who are on hunger strike", and should also conduct an independent and impartial investigation into the death of these two detainees.[17] Besides this more general call for medical supervision and

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14 <http://www2.ohchr.org/english/bodies/hrc/> (last accessed on 17 January 2012).

15 Human Rights Committee, view of 17 March 2006, Comm. 1184/2003, *Brough v Australia.*

16 Human Rights Committee, view of 26 March 2002, Comm. 763/1997, *Lantsova v Russia.* As early as in 1981, the Human Rights Committee stated that prisoners should be provided with necessary medical care: Human Rights Committee, view of 28 October 1981, Comm. 063/1979, *Setelich v Uruguay.*

17 CCPR/C/AUT/CO/4, under 12.

treatment of hunger strikers, the Human Rights Committee did not elaborate on this topic, and left the matter of force-feeding undiscussed.

2.1.7. CAT

The CAT is the body of ten independent experts that monitors implementation of the Convention against Torture by its States Parties. States Parties must submit regular reports to the CAT on how the rights are being implemented. They must report initially one year after acceding to the Convention against Torture, and then every four years. The responses to these reports are published as Concluding Observations. Furthermore, the CAT may also, under certain circumstances, consider individual complaints or communications from individuals, undertake inquiries and consider inter-state complaints. The CAT also publishes its interpretation of the content of the provisions of the Convention, known as General Comments on thematic issues.[18]

To my knowledge, the CAT has only addressed the issue of prisoners and detainees on hunger strike in one report: the 2003 consideration of a periodic report on Turkey. In this report, the CAT concluded that the introduction of so-called "F-type prisons" has led to hunger strikes causing the deaths of more than 60 inmates, and recommended that Turkey "solves the current problems in prisons generated by the introduction of 'F-type prisons' by implementing the recommendations of the CPT and by entering into serious dialogue with those inmates continuing hunger strikes".[19] The CAT only underlined the need for a serious dialogue with the hunger strikers, but referred to the recommendations of the CPT concerning this matter.

2.1.8. The Special Rapporteur on the right to health and the Special Rapporteur on torture

Special Rapporteurs are independent experts appointed by the Human Rights Council of the UN to examine and report back on a country situation or a specific human rights theme. They are not employed by the UN or paid for their work; their position is honorary. The Special Rapporteur expresses his view in an independent capacity and does not represent his government. The Commission on Human Rights, the UN human rights body, which was replaced by the Human Rights Council in June 2006, has mandated Special Rapporteurs to study particular human rights issues.[20] In the context of this book, two Special Rapporteurs are important: the Special Rapporteur on the right to health, and the Special Rapporteur on torture.

As stated above, the CESCR acknowledges in its General Comment No. 14 on Article 12 ICESCR that the right to health contains both freedoms and entitlements;

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18 <http://www2.ohchr.org/english/bodies/cat/> (last accessed on 17 January 2012).

19 28CAT/C/CR/30/5, under 5f and 7f.

20 <http://www2.ohchr.org/english/issues/health/right/> (last accessed on 17 January 2012).

the former includes the right to control one's health and body and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment, and experimentation. The State is under a legal obligation to refrain from denying or limiting equal access for all persons, including prisoners and detainees, minorities, asylum seekers and illegal immigrants. The mandate of the Special Rapporteur on the right to health was created by the Commission on Human Rights in April 2002 by Resolution 2002/31 and was extended by the Human Rights Council through its Resolution 6/29 of 14 December 2007. The Special Rapporteur carries out his mandate through different means and activities, including: 1) presenting annual reports to the Human Rights Council and General Assembly on the activities and studies undertaken in view of the implementation of the mandate, 2) monitoring the situation of the right to health throughout the world, identifying general trends, and undertaking country visits to witness the situation concerning the right to health in a specific country, 3) communicating with States and other parties concerned with regard to alleged cases of violations of the right to health and other issues related to his mandate, and 4) promoting the full realisation of the right to health through dialogue with relevant actors by participating in seminars, conferences and expert meetings.[21]

In Resolution 1985/33, the Commission on Human Rights decided to appoint a Special Rapporteur on torture to address questions relevant to torture. In June 2008, this mandate was extended for three years by Human Rights Council Resolution 8/8. The mandate covers all countries, irrespective of whether a State has ratified the Convention against Torture. The mandate comprises three main activities: 1) transmitting urgent appeals to States with regard to individuals reported to be at risk of torture, as well as communications on past alleged cases of torture; 2) undertaking fact-finding country visits; and 3) submitting annual reports on activities, the mandate and methods of work to the Human Rights Council and the General Assembly. When situations arise that come within the scope of more than one mandate established by the Commission, the Special Rapporteur may decide to approach other thematic mechanisms and country rapporteurs to send joint communications or seek joint missions.[22]

An example of such a joint mission is the observation of the situation of prisoners at the US Naval Base at Guantánamo Bay. In February 2006, a joint study was presented by the Chairperson of the Working Group on Arbitrary Detention, the Special Rapporteur on the independence of judges and lawyers, the Special Rapporteur on torture, the Special Rapporteur on freedom of religion or belief and the Special Rapporteur on the right to health on the situation of detainees at

21 Ibid.

22 <http://www2.ohchr.org/english/issues/torture/rapporteur/> (last accessed on 17 January 2012).

Guantánamo Bay.[23] These five holders of mandates of special procedures of the Commission on Human Rights had been jointly following this situation since January 2002. In June 2004, they decided to continue this task as a group because the situation fell under the scope of each of the mandates, and they could better discharge their reports to the Commission by submitting one joint report on this subject rather than five individual reports.[24] In this report, the term "detainees" is used; for the purposes of this book, this group of persons in custody would qualify as prisoners. For this reason, below I will refer to them as prisoners. The report, presented to the UN Economic and Social Council, address all the conditions at Guantánamo Bay, including reported force-feeding of hunger strikers.

In the sections on "Torture and other cruel, inhuman or degrading treatment or punishment" and "The right to the highest attainable standard of physical and mental health" the Special Rapporteur on torture and the Special Rapporteur on the right to health paid attention to the practice of force-feeding prisoners on hunger strike at Guantánamo Bay. In the former section the Special Rapporteur on torture noted that excessive force was routinely used in force-feeding during hunger strikes. According to reports by the defence counsels, some of the force-feeding methods clearly amounted to torture. One of these defence counsels describes the practice of force-feeding as follows

> "They [the prisoners] are being force-fed through the nose. The force-feeding happens in an abusive fashion as the tubes are rammed up their noses, then taken out again and rammed in again until they bleed. For a while tubes were used that were thicker than a finger because the smaller tubes did not provide the detainees with enough food. The tubes caused the detainees to gag and often they would vomit blood. The force-feeding happens twice daily with the tubes inserted and removed every time. Not all of the detainees on hunger strike are in hospital but a number of them are in their cells, where a nurse comes and inserts the tubes there."[25]

The Special Rapporteur on torture concluded that the excessive violence used in many cases such as force-feeding prisoners on hunger strike must be assessed as amounting to torture as defined in Article 1 of the Convention against Torture.[26] In this part of the report, the Special Rapporteur on torture only investigated the manner of force-feeding. Remarkably, it was the Special Rapporteur on the right to

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23 Situation of Detainees at Guantánamo Bay, UN Doc: E/CN.4?2006/120 (27 February 2006), available at < http://www.unhcr.org/refworld/country,,UNCHR,,CUB,,45377b0b0,0.html> (last accessed on 17 January 2012).

24 Ibid., p. 5, under 1 and 2.

25 Account given by Attorney Julia Taver (28 October 2005). Ibid., pp. 39-40, under footnote 73.

26 Ibid., p. 28, under 88.

health who elaborated on the ethical obligations of health professionals, including in relation to force-feeding.

According to the Special Rapporteur on the right to health, force-feeding of hunger strikers raises several distinct human rights issues. One issue concerns the manner in which prisoners are force-fed, already referred to by the Special Rapporteur on torture, but another concerns the ethics and legality of force-feeding, regardless of how it is undertaken. Under 80-82, he goes into this (although he notes that he only briefly addresses this issue "given the severe space constraints"). Under 81 he notes that the US policy of force-feeding prisoners on hunger strike is inconsistent with the principle of individual autonomy, the policy of the WMA as laid down in the Declarations of Tokyo and Malta that prohibit doctors from participating in force-feeding hunger strikers which the American Medical Association has endorsed, as well as the position of doctors of the ICRC. Under 82, he further states that

> "From the perspective of the right to health, informed consent to medical treatment is essential, as is its 'logical corollary' the right to refuse treatment [c.f. CESCR, General Comment No. 14 under 8 and 34]. A competent detainee, no less than any other individual, has the right to refuse treatment. In summary, treating a competent detainee without his or her consent – including force-feeding – is a violation of the right to health, as well as international ethics for health professionals."

The Special Rapporteur on the right to health concludes that the treatment of prisoners and the conditions of their confinement have led to prolonged hunger strikes. The force-feeding of competent prisoners not only violates the ethical duties of any health professionals who may be involved in it, but it also violates the right to health of the hunger striker involved; an opinion that had not been illustrated before.[27] On the basis of these findings, the joint report concludes by advising the US Government to ensure that the authorities in Guantánamo Bay do not force-feed any detainee who is capable of forming a rational judgment and is aware of the consequences of refusing food. Also they recommend the US Government to invite independent health professionals to monitor hunger strikers, in a manner consistent with international ethical standards, throughout the hunger strike.[28]

2.1.9. The ICTY

The ICTY is a UN court of law which was established in 1993, especially designed to deal with war crimes that took place during the conflicts in the Balkans in the 1990s. One of the suspects before the ICTY was Vojislav Šešelj, charged with war crimes committed in Bosnia and Herzegovina and Croatia between 1991 and 1994,

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27 Ibid., p. 28, under 94.

28 Ibid., p. 29, under 103.

during his time as the leader of the Serb Radical Party. He became very (in)famous for his disruptive behaviour towards the ICTY to obstruct the procedure pending against him. On 10 November 2006, during his pre-trial detention, he went on hunger strike until various demands were met. He protested against the limitation on the visits by his wife, demanded to have all his case documents in the Serbian language and in hard-copy format and asked that the stand-by counsel was removed from the proceedings. In addition, he requested to choose his own legal advisers. He also made additional demands, such as the disqualification of the judges then composing the bench and unfreezing of overseas assets.[29] In the beginning of December 2006, Šešelj's health rapidly deteriorated. As a result he was transferred to the prison hospital in Scheveningen, and the ICTY was compelled to suspend the trial because of his ill-health.[30] However, he remained very determined to prolong his hunger strike and made it clear that he rejected any form of medical treatment, resuscitation or feeding, even if he were to lose consciousness. He also declared that he had "consciously entered upon hunger strike in the pursuit of [his] requests" and that he had "neither the motivation nor the intention to commit suicide".[31]

After 27 days of hunger strike, a physician concluded that Šešelj's state of health had seriously deteriorated, and his situation might even become life-threatening. In response to this, the ICTY issued an "Urgent order to the Dutch authorities regarding health and welfare of the accused".[32] In this document, the Trial Chamber ordered the Dutch authorities to force-feed Šešelj if necessary to prevent him from dying as a result of his hunger strike. In the words of the ICTY "[t]he Trial Chamber is concerned that a situation might arise where the Accused's right to physical integrity and the obligation of the Tribunal to protect the Accused's health and welfare are in conflict". Force-feeding, in their view, was necessary because

> "[u]nder the present circumstances, the Trial Chamber finds that there is a prevailing interest in continuing with the trial of the Accused in order to serve the ends of justice. The trial […] should not be undermined by the Accused's manipulative behavior. In order to resume trial proceedings and fulfil the Tribunal's duty to protect the Accused's health and welfare, it is necessary for the Host State to take decisive measures."[33]

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29 *Urgent Order to the Dutch Authorities Regarding Health and Welfare of the Accused*. Trial Chamber ICTY, 6 December 2006, pp. 1-2.

30 'Process against Seselj temporarily discontinued' (*Proces tegen Seselj tijdelijk gestaakt)*, *NRC Handelsblad*, 2 December 2006 and 'Condition hunger striker Seselj worrisome' (*Toestand hongerstaker Seselj zorgwekkend), NRC Handelsblad*, 6 December 2006.

31 *Urgent Order to the Dutch Authorities Regarding Health and Welfare of the Accused*. ICTY Trial Chamber, 6 December 2006, p. 3.

32 Ibid., pp. 1-2.

33 Ibid., pp. 4-5.

Because of the manipulative nature of his hunger strike, and the fact that Šešelj had to live to stand trial so that justice could be done (see Ch. 4, § 3.6), the ICTY ordered the force-feeding of hunger striker Šešelj. In the "Considerations for the Host State", the ICTY elaborated on the legitimacy of force-feeding prisoners on hunger strike. In this context, the Trial Chamber noted that domestic and international legal standards on hunger strike reveal a lack of uniformity and reiterated different countries' viewpoints on the matter, but furthermore referred to the ECtHR's case law that allows force-feeding if there is a medical necessity, if procedural guarantees for the decision to force-feed are complied with, and if the manner in which the prisoner is force-fed is not inhuman or degrading (as observed in the *Nevmerzhitsky* case, see Ch. 5, § 3.4.6).[34] The ICTY's Trial Chamber also required that all authorised measures be taken to medically intervene in the interests of protecting the health and life of the hunger striker, even if this would include drip-feeding. Furthermore, it stated that

> "[a]t the same time, [it] is aware that the persistence of the Accused in refusing nourishment may reach a point where subsequent medical intervention may be met by an absolute obstacle, that being an obstacle not subject to any reasonable dispute, in generally accepted international standards of medical ethics. While recognising that the health and welfare of the Accused is the primary responsibility of the Registrar, the Trial Chamber's exercise of its authority in this regard stems – apart from its genuine concern with the well-being of an accused before it – from its responsibility to contribute to the performance of the Tribunal's judicial role in furtherance of the mission assigned to it by the international community."[35]

This passage raises several questions. What is meant by "subsequent medical intervention", that is met by an "absolute obstacle" that is "not subject to any reasonable dispute", for example? In my opinion, the subsequent medical intervention is likely to include the application of force-feeding. Still, it remains unclear whether this phrase refers only to force-feeding, or also to other medical intervention. Although the wording of this passage is very unclear and raises more questions than it answers, the Trial Chamber in my opinion attempted to say that, before his trial took place, in principle, the host State was allowed to force-feed Šešelj when medically necessary to preserve his life to make sure that he lived to stand trial. Although the title of this decision seemed to indicate great urgency for the host State to comply with the order, the actual disposition left considerable discretion to the Dutch authorities.[36] The Trial Chamber authorised the Netherlands

[34] Ibid., p. 5.

[35] Ibid., pp. 5-6.

[36] Sluiter 2007, p. 531.

> "to provide medical services under the Agreement – which may, in the case of medical necessity, include intervention such as drip-feeding – with the aim of protecting the health and welfare of the Accused and avoiding loss of life, to the extent that such services are not contrary to compelling internationally accepted standards of medical ethics or binding rules of international law."[37]

If, after this intervention to save his life, the hunger striker was determined to continue his hunger strike and refused to be force-fed, however, this decision must be respected and no more force-feeding was to be applied. Furtherance of life-saving interventions against the hunger striker's wishes in such a case would apparently, in the view of the Trial Chamber, contravene "internationally accepted standards of medical ethics or binding rules of international law". With "binding rules of international law" the Trial Chamber seems to refer to the legal lacuna that is left by the ECtHR to apply force-feeding. In this way, the Trial Chamber provided possibilities to intervene in Šešelj's hunger strike to preserve his life and ensure the administration of justice. However, it did not order life-saving intervention against all costs.

Because the Trial Chamber refers to "subsequent medical intervention", it only seems to consider repeated force-feeding to a determined hunger striker a violation of international medical ethics. Nevertheless, the question remains as to how the Trial Chamber would reconcile the initial application of force-feeding with internationally accepted standards of medical ethics. It is remarkable to see that the Trial Chamber, in this order, determined that force-feeding may be applied, but at the same time showed that it placed great value on the WMA Declaration of Malta, as it recommended that the applicable Protocol as used in the prison hospital where Šešelj was accommodated "should be reviewed to ensure conformity with the most recent developments in the standards of international medical ethics" i.e. the 2006 WMA Declaration of Malta.[38] Apparently, this document is an important source in the treatment of hunger strikers. But, as will be shown in Ch. 5, § 2.2.2, this declaration is strongly opposed to force-feeding in competent hunger strikers and states unequivocally that "forcible feeding is never ethically acceptable". Apparently, the Trial Chamber placed great value on this declaration, but only used it as a source for guidance on the procedural aspects of force-feeding, ignoring its key-message, i.e., that force-feeding competent hunger strikers is unethical, in doing so.

As already stated, this order left considerable discretion to the Dutch authorities. Nevertheless, it created a problem for the host State, the Netherlands. On the one hand, it was faced with this unambiguous ICTY order to force-feed the prisoner if necessary but, on the other hand, it had to comply with national legislation which

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[37] *Urgent Order to the Dutch Authorities Regarding Health and Welfare of the Accused*. ICTY Trial Chamber, 6 December 2006, p. 5.

[38] Ibid., p. 6.

provided ample scope for force-feeding.[39] The ICTY Trial Chamber acknowledged that "the health services provided to an accused [which should also provide the medical intervention of force-feeding] are embedded in the domestic penitentiary structures and general health care facilities of the host country, whereas the mission of the Tribunal is mandated by the international community".[40] This suggests that, although an accused remained in the custody of the Tribunal even when at the prison hospital, health care and treatment, including force-feeding, to the accused must be provided by Dutch physicians. This was also problematic, considering the fact that Dutch medical associations had repeatedly stated that they were strongly opposed to force-feeding competent prisoners on hunger strike and that physicians willing to apply this medical treatment would face disciplinary proceedings before the Central Medical Disciplinary Tribunal (*Centraal Medisch Tuchtcollege*).[41] Besides, on an international level, the WMA Declarations of Tokyo and Malta declare force-feeding in competent hunger strikers ethically unacceptable for physicians. If the force-feeding were not applied by Dutch physicians, but by physicians in the employ of the ICTY (such as the Medical Officer), this would still be problematic. It can be concluded that the Trial Chamber confronted the Dutch authorities with the difficult – if not impossible – task of applying force-feeding, deemed necessary for lifesaving purposes, in a way that would not contradict "internationally accepted standards of medical ethics or binding rules of international law". As Welsh rightfully noted, this ambivalent order appeared to attempt to achieve mutually conflicting goals; it ordered doctors to force-feed prisoners, but at the same time those doctors had to behave in a manner consistent with international medical ethics which proscribes such force-feeding.[42] Sluiter also criticised the approach of the Trial Chamber, leaving the decision on whether to force-feed the prisoner on hunger strike and the responsibility for this decision to the host State, as reflected in this force-feeding order, by stating that

> "[i]t is quite disconcerting that the analysis of these international standards and rules is left to the host state and not performed by the Trial Chamber itself. The latter, as an international tribunal, is best placed to conduct such an analysis. One has the impression that the order is the result of an urgent sense that "something had to be done", but that the courage was lacking to take full responsibility for providing solutions to difficult questions."[43]

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39 However, in 2002, Minister of Justice Donner stated that Dutch law allows the force-feeding of competent prisoners on hunger strike. See Ch. 6, § 2.8.

40 Ibid., p. 4.

41 See Ch. 6, § 2.

42 Welsh 2009, p. 160.

43 Sluiter 2007, pp. 531-532.

It can be concluded that the force-feeding order itself, and the execution of it by the host State, was problematic. The Trial Chamber must have had regard to this. Why then did it order the application of force-feeding? In my view, this approach can be explained by the ICTY's task as mentioned on its website: to investigate and prosecute offenders of serious crimes against humanity and to make sure "that leaders suspected of mass crimes will face justice".[44] If the suspect died as a result of his hunger strike, he would no longer be able to face justice. What, in my opinion, may also have influenced this decision to force-feed is that earlier that year (on 11 March 2006), Slobodan Milošević died whilst in pre-trial detention. A couple of days earlier, on 5 March 2006, a detained witness in the case of *Milan Martić* before the ICTY, Croatian Serb leader Milan Babić, committed suicide in Scheveningen. After these deaths, it was vital to prevent this other high profile prisoner from dying. In my opinion, the Trial Chamber's force-feeding order was an emergency decision in response to the rapidly deteriorating health of Šešelj. Still, the Trial Chamber left the responsibility for deciding on force-feeding and for answering these difficult legal and medical-ethical questions to the host State. I will deal with the response of the Dutch authorities in Ch. 6, § 2.9.

In the end, no force-feeding was applied. Šešelj stopped his hunger strike on 8 December 2006, two days after the Trial Chamber had ordered his force-feeding, after several of his demands had been met.[45] From that moment on, his right to self-representation was fully restored and all documents were delivered to him in full, in Serbian, and in hard copy.[46] Although force-feeding was not applied, and it remains uncertain if, and if so, how and by whom it would have been applied, this order is an important signal that, in such a high profile case before an international war tribunal, the administration of justice can be an imperative, overriding issues of self-determination.[47]

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44 <http://www.icty.org/sections/AbouttheICTY> (last accessed on 17 January 2012).

45 'Seselj ends hunger strike after 28 days' (*Seselj eindigt hongerstaking na 28 dagen*), *NRC Handelsblad* 9 December 2006.

46 ICTY Appeals Chamber Decision of 8 December 2006. For a critical note on this decision, see Sluiter 2007.

47 On the ICTY's website a document with information for detainees who engage in voluntary protest fasting (the term the ICTY uses to indicate a hunger strike) can be found. In this document it is stated that prisoners on hunger strike "will be treated in accordance with the internationally accepted standards of medical ethics on the treatment of hunger strikers. In particular, the revised version of the World Medical Association […] Declaration on Hunger Strikers, which was adopted in October 2006, known as the Declaration of Malta." This document furthermore states that "Force feeding will not be undertaken" and when hunger striker decide to take their strike to the end, they "will be allowed to die with dignity rather than being resuscitated against [their] will." Although this document seems to be of a later date than October 2006 (as it refers to the in October 2006 revised edition of the Malta Declaration), it is undated. Inquiries at the ICTY have not led to clarity on the date of this document and its current status. For this reason, it remains unclear whether it was already applicable at the time of Šešeljs hunger strike (and apparently was

2.1.10. Conclusions

What can be concluded from the above-mentioned UN agreements on the question of force-feeding? The UN Principles of Medical Ethics and the SMR do not contain provisions for the use of force-feeding of prisoners and detainees on hunger strike, but contain provisions for the use of restraining prisoners and detainees in general. Both these documents show a reserved approach to the use of restraining instruments in general. In the Principles of Biomedical Ethics and the SMR, however, there is scope for using restraining instruments on prisoners and detainees. In this way, these documents provide some guidance in deciding on the use of restraining instruments. Still, they do not provide us with an answer to the principal question on the legitimacy of force-feeding. It can be concluded that there is no UN standard concerning force-feeding of prisoners and detainees on hunger strike. This may suggest that this delicate matter is left to be judged in individual cases, as could be done through the different UN human rights mechanisms. Still, the legality of force-feeding prisoners and detainees on hunger strike has rarely been exposed to judicial scrutiny. Although the Human Rights Committee and the CAT touched upon the matter briefly, they do not provide much insight into their views on the topic. They only underline the importance of adequate medical supervision and an ongoing dialogue with the hunger strikers involved.

More clarity on the matter is provided in the report of the Special Rapporteurs on torture and the right to health on the situation of prisoners at Guantánamo Bay, apparently a case in which a need was felt to clarify that the force-feeding practices in this case were unacceptable. In this report, the manner of force-feeding was investigated first. The Special Rapporteur on torture concluded that the excessive violence used must be assessed as amounting to torture as defined in Article 1 of the Convention against Torture. The principal question on force-feeding, however, was only assessed by the Special Rapporteur on the right to health, who concluded that prisoners or detainees who are capable of forming a rational judgment and are aware of the consequences of refusing food (in other words: persons who are competent) may not be force-fed. This statement is unique, as it is phrased in unambiguous terms, and because it states that force-feeding of competent prisoners not only violates the ethical duties of any health professionals who may be involved, but also violates the right to health of the hunger striker involved, an opinion that has not been advanced before. A very different view was held by the Trial Chamber of the ICTY when confronted with a prolonged hunger strike of alleged war criminal Šešelj. In this case, the Trial Chamber issued a force-feeding order to the

set aside because of the apparently unique set of facts that this justified a breach of policy), or this is a new policy on the issue, created after the events concerning Šešelj. ICTY, "Voluntary protest fasts – Information for detainees", available at <http://www.icty.org/x/file/Legal%20Library/Detention/voluntary_protest_fast-info_for_dets_rev_090325.pdf> (last accessed on 17 January 2012), pp. 1 and 4.

Netherlands, in which it ordered the host State to force-feed the competent hunger striker to prevent him from dying to make sure he could stand trial. Although the force-feeding order shows awareness of the fact that medical ethics are important in assessing the legitimacy of force-feeding in a particular case, the Trial Chamber determined that the administration of justice prevailed over the hunger striker's individual rights.

2.2. THE WMA

The WMA is an international organisation representing physicians. It was founded in 1947, shortly after the Nuremberg trials, which revealed and documented the abuses of medicine in concentration camps. The WMA aims to ensure the independence of physicians and to work for the highest possible standards of ethical behaviour and care by physicians, at all times. The WMA is funded by the annual contributions of its members, 95 national medical associations.[48] The WMA is the only worldwide organisation that has issued ethical guidelines that specifically deal with the topic of prisoners and detainees on hunger strike.[49] Two WMA documents concern this issue, i.e., the Declarations of Tokyo and the two subsequent versions of the Declaration of Malta (1991, with revisions in 1992 and 2006). These documents are not binding on States, but only contain guidelines for doctors involved in the treatment of hunger strikers. On an international level, there is no instrument to observe the compliance of physicians with the WMA rules and declarations. Still, they can be invoked in national medical disciplinary procedures against individual physicians, and they can form the basis of appeals to urge those breaching the WMA guidelines to be held accountable by their professional bodies in their place of registration.[50] Despite their lack of binding effect, they are considered as authoritative for the ethical management of prisoners and detainees on hunger strike worldwide.

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48 <https://www.wma.net> (last accessed on 17 January 2012).

49 On a national level, the Dutch Johannes Wier Foundation, and the British Department of Health have also issued guidelines for the treatment of hunger strikers. See Ch. 5, § 4.4 and Ch. 6, § 4.9.

50 This was, for instance, the case in an attempt of the Medical Foundation for the Care of Victims of Torture (London, UK) in January 2006 to persuade the Council on Ethical and Judicial Affairs of the American Medical Association (a co-signatory to both the Declarations of Tokyo and Malta, and a constituent member of the WMA) to undertake disciplinary actions against physicians who had applied force-feeding to competent hunger strikers at US Naval Base at Guantánamo Bay. Dr William Hopkins of the Medical Foundation for the Care of Victims of Torture was one of the authors of the Correspondence Letter to the *Lancet*, in which he, supported by 255 other doctors, opposed force-feeding practices at Guantánamo Bay, and urged "the US government to ensure that detainees are assessed by independent physicians and that techniques such as forcefeeding and restraint chairs are abandoned forthwith in accordance with internationally agreed standards". Nicholl et al. 2006.

2.2.1. The Declaration of Tokyo[51]

The WMA Declaration of Tokyo was adopted in 1975, during the 29th General Assembly of the WMA, and was editorially revised in 2005 and 2006. In the Declaration of Tokyo, the WMA aimed to develop guidelines for difficult situations where the State uses or condones torture or other harmful practices, and physicians are asked, or forced, to attend to the victims. In 1975, the Declaration of Tokyo stated that

> "[i]t is the privilege of the medical doctor to practice medicine in the service of humanity, to preserve and restore bodily and mental health without distinction as to persons, to comfort and to ease the suffering of his or her patients. The utmost respect for human life is to be maintained even under threat, and no use made of any medical knowledge contrary to the laws of humanity."[52]

The WMA's explanatory guidelines for the Declaration of Tokyo which came out when the Declaration was editorially revised, state that

> "[w]hile physicians have an obligation to diagnose and treat victims of torture, they are ethically prohibited from conducting any evaluation, or providing information or treatment, that may facilitate the future or further conduct of torture. Such actions constitute physician participation in torture, which is not only unethical, but also facilitates the acceptance of such procedures, and ultimately destroys patients' trust in the medical profession."[53]

By setting clear guidelines, the WMA aims to prevent the abuse of medical knowledge in situations in which physician's medical-ethical behaviour is under scrutiny.

In the Declaration of Tokyo, the WMA elaborated on such cases to prevent physicians countenancing, condoning or participating in the practice of torture, cruel, inhuman or degrading treatment or punishment. Article 5 of the 1975 Declaration of Tokyo Article 5 (after the 2006 revision Article 6) states that

> "[w]here a prisoner refuses nourishment and is considered by the physician as capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially. The decision as to the capacity of the prisoner to form such a judgment should

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51 WMA, Declaration of Tokyo. Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment. Adopted by the 29th World Medical Assembly, Tokyo, Japan, October 1975, and editorially revised at the 170th Council Session, Divonne-les-Bains, France, May 2005, and the 173rd Council Session, Divonne-les-Bains, France, May 2006, <http://www.wma.net/en/20activities/10ethics/20tokyo/index.html> (last accessed on 17 January 2012).

52 Declaration of Tokyo 1975, Preamble.

53 Declaration of Tokyo 1975.

> be confirmed by at least one other independent physician. The consequences of the refusal of nourishment shall be explained by the physician to the prisoner."

The Declaration of Tokyo values the determination of competence ("capacity") as it states that this decision should be confirmed by at least one other independent physician. The fact that the fasting prisoner be duly informed is highlighted in this declaration, emphasising that the hunger striker should be told about the consequences on his health of his action.

Why does this declaration, which is essentially on the prohibition of medical participation in torture and other such abuses, contain an article on hunger strikes? According to Reyes, one common explanation for this is that force-feeding is viewed as a form of torture, which, according to him, "indeed it may be on occasion". However, in his opinion, this is not the real reason behind the inclusion of a clause on force-feeding in the Declaration of Tokyo. Reyes states that

> "[t]he real reason for Article 5 is, however, different (personal communication by Dr. André Wynen, former and Honorary Secretary-General and founding member of the WMA). The ban on force-feeding relates to the background to the declaration, i.e. situations of torture. If a prisoner undergoing torture decided to protest against his plight by going on a hunger strike, a doctor should not be obliged to administer nourishment against the prisoner's will and thereby effectively revive him for more torture. This was the key issue behind the inclusion of Article 5 relating to hunger strikes."[54]

This reason behind the inclusion of this clause of force-feeding reveals that this Article is not about hunger strikers who fast because they lack other means of making their grievances known, but is about prisoners being tortured who can only escape torture, they hope, by starving themselves. This is a different situation.[55]

This provision on force-feeding (although the Declaration of Tokyo and the 1991 Declaration of Malta do not mention "force-feeding" but "artificial feeding", force-feeding is probably what is meant this was only remedied in the 2006 revision) has remained unchanged since the adoption of this Declaration in 1975. It shows that the WMA is very concerned with the issue of force-feeding prisoners and detainees on hunger strike. However, the Declaration of Tokyo leaves a number of questions open, as it is not about hunger strikes, but about situations of torture. Also, it does not address fundamental issues such as the question of whether intervention can be justified after a hunger striker becomes incompetent as a result of his actions. The WMA has elaborated on the issue of prisoners and detainees on hunger strike in the more recent Declaration of Malta, which is entirely devoted to this issue.

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54 Reyes 1998.

55 Personal communication with Hernán Reyes d.d. 18 February 2011.

2.2.2. The Declaration of Malta[56]

The Declaration of Malta was drafted in 1991, and editorially revised in 1992 and 2006. The Declaration of Malta is entirely about hunger strikes, independent of any other issue such as torture or ill-treatment, as was the case in the Declaration of Tokyo. The Declaration of Malta concerns hunger striking as a way to protest in custodial settings, the fasting being used as a last resort. It also categorises the different forms of food refusal that are not to be treated in the same way as hunger strikes. The review of the 1991 Declaration of Malta was inspired by several factors, some related to the evolving nature of hunger strikes, and others related to the way they were being managed by medical staff in certain situations.[57] In its Preamble, the Declaration states that "[g]enuine and prolonged fasting risks death or permanent damage for hunger strikers and can create a conflict of values for physicians". It emphasises that physicians need to ascertain the individual's true intention, especially, but not exclusively, in collective hunger strikes. Difficult ethical dilemmas arise when, for example, hunger strikers who have issued clear instructions not to be resuscitated reach a stage of cognitive impairment, or when it is unclear whether the hunger striker's advance instructions where made voluntarily and with appropriate and sufficient information about the consequences. The Declaration of Malta and the Background Paper published in the *World Medical Journal* address these and other difficult situations.[58]

The Declaration of Malta is applicable to all persons who are deprived of their liberty, i.e. prisoners and detainees. Although the text refers only to "detainees", the Preamble states that "[h]unger strikes occur in various contexts but they mainly give rise to dilemmas in settings where people are detained (prisons, jails and immigration detention centres)". In my view, the formulated Principles and Guidelines are therefore applicable to anyone in custody, i.e., both prisoners and detainees. This is underlined by the fact that, in most of the Declaration, the more neutral terms "hunger striker" or "patient" are used, the latter emphasising the physician-patient relationship. Before 2006, a hunger striker was defined in the Declaration as a "mentally competent person who has indicated that he has decided to embark on a hunger strike and has refused to take food and/or fluids for a significant interval". With the revision of 2006, this definition was removed from the document. In its Background Paper, however, the WMA still exclude short-lived fasts which end within 72 hours. If hunger strikers refuse both nutrition and hydration for more than 48 hours, however, they risk significant harm (see Ch. 1, § 2.5.3). According

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56 WMA Declaration of Malta on Hunger Strikers. Adopted by the 43rd World Medical Assembly Malta, November 1991, editorially revised at the 44th World Medical Assembly Marbella, Spain, September 1992, revised by the WMA General Assembly, Pilanesberg, South Africa, October 2006.

57 Reyes 2007, p. 703.

58 WMA 2006.

to the WMA, "[d]ry fasting without any fluid intake which persists for more than a few days would fall within the definition of 'hunger strike' used here but, fortunately this is rare." Although a definition of hunger strike was no longer part of the Declaration of Malta after the 2006 revision, in the Background Paper it is stated that the term "hunger strike" as used in that document refers to protest fasting without any intake of food but with ingestion of adequate quantities of water.[59] Other than the former definition, this definition stresses the aspect of protest involved in a hunger strike, and the applicability of the Declaration to hunger strikes that are employed as a form of protest.

In the Declaration of Malta, seven Principles are formulated for physicians involved in the management of hunger strikers.[60] The first Principle determines that physicians are under a duty to act ethically, especially when working with vulnerable people, such as those in custody. "Whatever their role, physicians must try to prevent coercion or maltreatment of detainees and must protest if it occurs." Principles 2 and 3 contain important rules concerning respect for the hunger striker's autonomy and force-feeding. They read as follows.

> 2. Respect for autonomy. Physicians should respect individuals' autonomy. This can involve difficult assessments as hunger strikers' true wishes may not be as clear as they appear. Any decisions lack moral force if made involuntarily by use of threats, peer pressure or coercion. Hunger strikers should not be forcibly given treatment they refuse. Forced feeding contrary to an informed and voluntary refusal is unjustifiable. Artificial feeding with the hunger striker's explicit or implied consent is ethically acceptable.
>
> 3. "Benefit" and "harm". Physicians must exercise their skills and knowledge to benefit those they treat. This is the concept of "beneficence", which is complemented by that of "non-maleficence" or *primum non nocere*. These two concepts need to be in balance. "Benefit" includes respecting individuals' wishes as well as promoting their welfare. Avoiding "harm" means not only minimising damage to health but also not forcing treatment upon competent people nor coercing them to stop fasting. Beneficence does not necessarily involve prolonging life at all costs, irrespective of other values.

The second Principle states that the hunger striker's autonomy must be respected. Under this Principle, however, it is also acknowledged that assessing the hunger

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59 Ibid., p. 36.

60 The Declaration of Malta consists of a "Preamble", "Principles" and "Guidelines for the Management of Hunger Strikers", each with their own pagination. For readability purposes, besides referring to the articles of these separate sections, when not indicated otherwise, I will use the consecutive numbering of the articles.

strikers' true wishes may be problematic. Nevertheless, when the hunger striker makes an informed and voluntary decision to refuse food (i.e. when there is a informed refusal), this decision must be respected; force-feeding contrary to an informed and voluntary refusal is unjustifiable. This statement is underlined in the part of the document containing the "Guidelines for the management of hunger strikers" (Articles 9-21), but is also phrased as one of the core Principles of the Declaration. According to the third Principle, such an approach is in accordance with the principle of beneficence, as this does not imply prolonging life at all costs. The Glossary in the Background Paper adds that "[a]n assessment of best interests must be a balance between seeking the best medical outcome and a consideration of the patient's own views, values and preferences. Physicians do not act in the patients' best interests by overriding patients' strongly held wishes".[61]

The fourth Principle goes into the issue of dual loyalties; the dilemma between the physician's loyalty to his employing authority (mostly the management of the prison or other place of detention) and his hunger striking patient (see Ch. 3, § 3). According to this Principle, the physician's primary obligation must be to the individual patient. This view is reflected in the fifth Principle, which determines that physicians must remain objective in their assessments, and must not allow third parties to influence their medical judgment. According to this Principle, they must not allow themselves to be pressured into breaching ethical principles, such as intervening medically for non-clinical reasons. Accordingly, the physician must be a physician for his patient, as he would be in the outside world. Although he is employed by the prison or other place of detention, he must still only be guided by his medical-ethical principles and must resist any pressure to violate them.

In the part of the Declaration containing "Guidelines for the management of hunger strikers", the WMA elaborates on the issue of force-feeding in Articles 20 and 21:

> 20. Artificial feeding can be ethically appropriate if competent hunger strikers agree to it. It can also be acceptable if incompetent individuals have left no unpressured advance instructions refusing it.
>
> 21. Forcible feeding is never ethically acceptable. Even if intended to benefit, feeding accompanied by threats, coercion, force or use of physical restraints is a form of inhuman and degrading treatment. Equally unacceptable is the forced feeding of some detainees in order to intimidate or coerce other hunger strikers to stop fasting.

As stated in Principles 2 and 3, the WMA here asserts that force-feeding is never ethically acceptable but constitutes a form of inhuman and degrading treatment, even if it is intended to benefit the hunger striker involved. In this respect, Dr Otmar Kloiber, Secretary-General of the WMA, noted that

[61] WMA 2006, under "Glossary Declaration of Malta", p. 41.

> "This new guidance makes it absolutely clear that physicians should never be used to break hunger strikes through acts such as force-feeding. The clarification was necessary because there had been erroneous interpretations of the Declaration, making it seem to allow force-feeding in the best interests of the patient, even when he had expressed wishes to the contrary. This interpretation appeared to contradict another WMA policy, the Declaration of Tokyo, which specifically stipulates that prisoners on hunger strike who have made an informed refusal of food shall not be artificially fed."[62]

Accordingly, the hunger striker's decision to stop eating must be respected by the physician. Force-feeding, in this respect, differs from artificial feeding (see Ch. 1, § 2.4). If the hunger striker consents, the feeding does not involve the use of coercion, so it is not called force-feeding, but artificial feeding. Artificial feeding is acceptable if hunger strikers make known their agreement to it by any means, usually by confiding in the doctor. If they are incompetent and have not refused it in advance artificial feeding is also allowed.

In some cases, the hunger striker will no longer be able to consent, as he may have already lost the mental capacity to discuss his wishes regarding medical intervention to preserve life. Two possible scenarios then emerge, depending on whether the hunger striker has issued advance instructions.

The first scenario is that the hunger striker has issued advance instructions. If this is the case, according to the Declaration under Article 17, the physician needs to consider these advance instructions. Advance refusals of treatment must be respected if they reflect the voluntary wish of the hunger striker when he was still competent. If the physician has serious doubts about the individual's intention (for example if he suspects that the advance instructions were made under pressure), these instructions must be treated with great caution. In general, if well-informed and voluntarily made, however, advance instructions can only be overridden if they have become invalid because the situation in which the decision was made has changed radically since the individual lost competence, so that the advance refusal may be considered inapplicable, or if the physician thinks that the refusal was made under duress. Still, if the hunger striker has regained competence and persists in his food refusal, the physician should allow the hunger striker to die in dignity rather than submit him to repeated interventions against his will.

Physicians may consider it justifiable to go against advance instructions refusing treatment if, for example, they think they were made under duress. Article 17 of the Declaration of Malta determines that the physician may resuscitate the hunger striker once only. If, after the hunger striker has regained his mental faculties, he continues to reiterate his intention to fast, this decision should be respected. Accord-

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62 <http://www.wma.net/en/40news/20archives/2006/2006_10/index.html> (last accessed on 17 January 2012).

ing to the Declaration under Article 19, it is "ethical to allow a determined hunger striker to die in dignity rather than submit that person to repeated interventions against his or her will".

The second scenario is that the hunger striker has lost mental capacity and no advance directive exists. If this is the case, according to the Declaration under Article 18, physicians have to act in what they judge to be the person's best interests, a decision which may include force-feeding. To this end, the physician has to consider the hunger striker's previously expressed wishes, his personal and cultural values, and his physical health. The final decision on force-feeding must lie with the physician, and not with any non-medical authority or third party, who must take into account the hunger striker's informed decision on the food or treatment refusal.

According to the Declaration under Article 15, the physician involved must make clear at the outset whether he is able to respect a hunger striker's refusal of treatment or feeding. If, for reasons of conscience, he cannot accept the patient's decision, he should make this clear and refer him to another physician who is willing to do so.

Besides force-feeding, the Declaration of Malta contains valuable guidelines for physicians on the treatment of prisoners and detainees on hunger strike, such as

- the duty to maintain confidentiality (Article 7)
- the need for physicians to establish a relationship of trust with the patient (Article 8)
- the need to assess the hunger striker's mental capacity (Article 9)
- the need for a thorough examination of the hunger striker and his values and wishes regarding medical treatment in the event of a prolonged fast at the beginning of the fast (Article 11) and
- the duty to acquire a detailed and medical history of the person who is intending to fast, as early as possible (Article 10).

The Declaration furthermore emphasises that the hunger striker's decision to fast and refuse treatment must meet the requirements of a true informed refusal; the physician must verify that the hunger striker understands the potential health consequences of fasting and forewarn him in plain language of the disadvantages. The physician must also inform the hunger strike on how to minimise or delay the harmful consequences of his actions by, for example, increasing fluid and vitamin intake (Article 10, and Glossary, under "Autonomy"). He must also ensure full patient understanding of the medical consequences of fasting by asking the patient to repeat back what he understand (Article 10). Furthermore, the physician needs to satisfy himself that the food or treatment refusal is the individual's choice, and he is not coerced by his peer group, the authorities or others, such as family members Article 14. Consent and refusal are invalid if the result of coercion (Glossary, under "Autonomy"). Under "Undue pressure/coercion" in the Glossary, it is stated that

"[i]nforming hunger strikers of the implications of their decisions and encouraging them to reflect are essential and do not constitute undue pressure". Attempting to dissuade them from their decision by threats, such as the threat of force-feeding, however, is not acceptable. This reflects the elements of informed consent and refusal as described in Ch. 2, § 4.2, such as competence, the voluntary aspect of any decision to prolonged fasting, disclosure, and understanding. The Background Paper on the Declaration of Malta also acknowledges that "[t]he informed and voluntary nature of individuals' food refusal are key aspects that physicians need to ascertain once mental competence has been established".[63]

2.3. THE INTERNATIONAL COUNCIL OF NURSES

Not only physicians, but also nurses can be involved in the treatment of prisoners and detainees on hunger strike. They are often responsible for the daily care and treatment of the hunger striker, which intensifies as a hunger strike continues, the hunger striker needs more medical supervision and even to be admitted to a hospital or prison ward. As with physicians, nurses can be faced with ethical dilemmas in the treatment of hunger strikers, if they are asked to participate in force-feeding. For this reason, it is interesting to investigate the view of this group of health professionals on this topic.

To this end, I investigated the documents of the International Council of Nurses (hereafter: ICN). The ICN is the international representative body for nurses. The ICN was founded in 1899 and is currently (January 2012) a federation of more than 130 national nurses associations, representing in total more than 13 million nurses worldwide. The aim of the ICN is to "ensure quality nursing care for all, sound health policies globally, the advancement of nursing knowledge, and the presence worldwide of a respected nursing profession and a competent and satisfied nursing workforce".[64] Several statements adopted by the ICN are relevant to the question of force-feeding prisoners and detainees on hunger strike. Obviously, these statements do not have binding legal force, but merely serve as guidelines for the nurses' conduct.

The ICN "Code of ethics for nurses" is a guide for action based on social values and needs. It was first adopted by the ICN in 1953 and has been revised and reaffirmed at various time since, most recently in 2006.[65] In the Preamble, it states that

> "[i]nherent in nursing is respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect. Nursing care is respectful

[63] WMA 2006, p. 37.

[64] <http://www.icn.ch/about-icn/about-icn/> (last accessed on 17 January 2012).

[65] Text available online at <http://www.icn.ch/about-icn/code-of-ethics-for-nurses/> (last accessed on 17 January 2012).

> of and unrestricted by considerations of age, colour, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status.

This Code furthermore states that "[t]he nurse ensures that the individual receives sufficient information on which to base consent for care and related treatment." Accordingly, nurses as well as physicians are ethically obliged to provide information to patients to ensure valid informed consent. The ICN has elaborated on the role of nurses in human rights issues in a document entitled "Nurses and Human Rights", in which the ICN states its position as follows.[66]

> "Human rights in health care involve both recipients and providers. The ICN views health care as a right of all individuals, regardless of financial, political, geographic, racial or religious considerations. This right includes the right to choose or decline care, including *the right to accept or refuse treatment or nourishment*; informed consent; confidentiality, and dignity, including the right to die with dignity." [Emphasis added]

Here, the ICN acknowledges a right to health care for all persons, including prisoners and detainees, which includes, *inter alia*, the right to accept or refuse treatment or nourishment and the right to die with dignity.[67] This suggests that the ICN demands respect for the decision to go on hunger strike and rejects forced intervention.

In addition, this document states that

> "[n]urses have an obligation to safeguard people's health rights at all times and in all places. This includes assuring that adequate care is provided within the resources available and in accordance with nursing ethics. Besides, the nurse is obliged to ensure that patients receive appropriate information prior to consenting to treatment or procedures, including participation in research."

It can be concluded that although the hunger striker's decision to refuse treatment or nourishment must be respected, the nurse must still assure that he receives adequate care. The nurse must also provide information to the patient prior to treatment or procedures. In my view, this last sentence must be understood in a way that is also (and maybe even more so) applicable to patients who *refuse* certain treatments or procedures, since this decision may have far-reaching consequences for the patient's health.

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66 ICN, Nurses and Human Rights, 1998. The ICN adopted a position on "The Nurse's Role in the Safeguarding of Human Rights" in 1983; the statement was revised in 1993 and then replaced by the 1998 ICN statement "Nurses and Human Rights".

67 This view resembles the view of the Special Rapporteur on the Right to Health (see § 2.1.8 of this chapter).

In 1998, the ICN looked at nurses' role in the care of prisoners and detainees in a document with identical wording.[68] In this document, the ICN endorses the UN Universal Declaration of Human Rights and the 1949 Geneva Conventions and additional protocols and asserts that "prisoners and detainees have the right to health care and humane treatment" and "have a right to refuse treatment or diagnostic procedures and to die with dignity and in a peaceful manner". In this document, unlike in "Nurses and Human Rights", the ICN does not explicitly acknowledge a right to accept or refuse treatment *or nourishment* for prisoners and detainees, solely a right to refuse treatment, and, in this way, leaves the issue of respect for food refusal by a prisoner or detainee untouched. The reason behind the reluctance to acknowledge such a right is unclear. It can be explained by reticence or lack of obligation to acknowledge such a right for prisoners and detainees, but can also be explained by the fact that such a right already had been acknowledged by the ICN for all persons, including prisoners and detainees, in the document "Nurses and Human Rights" of the same year.

2.4. CONCLUSIONS

For the WMA, the issue of prisoners and detainees on hunger strike and force-feeding has always been important. This is reflected in the 1975 Declaration of Tokyo, which contains a stipulation on this issue, and the 1991 Declaration of Malta, with its revisions in 1992 and 2006, which is entirely devoted to the issue of hunger strikes, much attention also being paid to force-feeding. Although the Declaration of Malta goes into the issue more extensively, the view of the WMA in both documents is identical: force-feeding of prisoners and detainees is never ethically acceptable. The view of the WMA that force-feeding of prisoners and detainees is never ethically acceptable was underlined in the 2006 revision of the Declaration of Malta, which was used to strongly reiterate the view that force-feeding of hunger strikers is not only unethical, but can never be justified, and constitutes a form of inhuman and degrading treatment. In this Declaration, only limited exceptions are created to apply food to the prisoner or detainee involved.

The position of the WMA can be compared with the position of the ICN, which has stated that all individuals (including prisoners) have a right to health care, which includes the right to accept or refuse treatment or nourishment. Although the Declarations of Tokyo and Malta and the documents of the ICN are merely guidelines that are not binding on States, most national medical associations (95 in total) have committed themselves to the WMA and their declarations, and more than 130 national nurses associations have committed themselves to the ICN and

[68] ICN, The Nurse's Role in the Care of Prisoners and Detainees, 1998. This document replaced the previous ICN position "The Nurse's Role in the Care of Detainees and Prisoners", adopted 1975.

its positions. In this way, the Declarations of Tokyo and Malta and position of the ICN form important medical-ethical guidelines for physicians and nurses who are involved in the management of hunger strikes.

3. EUROPEAN DOCUMENTS AND CASE LAW ON FORCE-FEEDING PRISONERS AND DETAINEES ON HUNGER STRIKE

Besides international human rights documents and treaties as illustrated above, different documents have been drafted, mainly by the Council of Europe, which contain rights for persons who are deprived of their liberty in European prisons and other places of detention. In the next part, I will investigate the European legal framework on force-feeding prisoners and detainees on hunger strike.

To this end, I will discuss the Recommendation Concerning the Ethical and Organisational Aspects of Health Care in Prison, the EPR, and the Biomedicine Convention on the issue of force-feeding. Despite their non-binding character of these recommendations, the ECtHR attaches substantial importance to them in considering cases concerning prisoners' rights and other prison issues.[69] I will subsequently go into the case law of the EComHR and ECtHR on the issue of force-feeding and explore the view of the CPT on this topic.

3.1. RECOMMENDATION CONCERNING THE ETHICAL AND ORGANISATIONAL ASPECTS OF HEALTH CARE IN PRISONS AND FORCE-FEEDING PRISONERS AND DETAINEES ON HUNGER STRIKE

The Council of Europe's Recommendation Concerning the Ethical and Organisational Aspects of Health Care in Prisons contains several provisions which are relevant for the refusal of treatment and hunger strike.[70] In this document, the terms prisoner, detainee, detained person and inmate appear. In my opinion, it can therefore be concluded that this Recommendation concerns all persons in custody. The recommendation addresses the main characteristics of health care in prison, the role of health care personnel and the practical organisation of health care in prisons and other places of detention. Article 20 of the Recommendation deals with the issue of professional independence. Here it is stated that clinical decisions and any other

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69 See, for example, ECtHR 18 December 2007, *Dybeku v Albania,* App. No. 41153/06, paragraph 48 and ECtHR 11 July 2006, *Rivière v France,* App. No. 33834/03, paragraph 72.

70 Council of Europe, Recommendation No. R (98) 7 (1) of the Committee of Ministers to member states concerning the ethical and organisational aspects of health care in prison (adopted by the Committee of Ministers on 8 April 1998, at the 627th meeting of the Ministers' Deputies).

assessments regarding the health of prisoners or detainees involved should be governed by medical criteria. Furthermore, health care personnel should operate with complete independence within the bounds of their qualifications and competence. Accordingly, physicians and health care personnel must decide on the basis of their own medical criteria, independent from such third parties as the custodial board.

Articles 13-18 describe patient consent and confidentiality. Under Article 14, it is stipulated that, unless inmates suffer from any illness which renders them incapable of understanding the nature of their condition, they should always be entitled to give informed consent before any physical examination of their person or their body products can be undertaken, except in cases provided by law. Article 15 adds that informed consent should also be obtained in the case of the mentally ill, "as well as in situations when medical duties and security requirements may not coincide, for example refusal of treatment or refusal of food". Article 16 adds that any derogation from the principle of freedom of consent should be based upon law and should be guided by the same principles as are applicable to the population as a whole. It can be concluded that informed consent is required, also in hunger strikes, before any physical examination may be performed.

Articles 60-63 of the Recommendation specifically go into the issue of hunger strike and refusal of treatment.

> 60. In the case of refusal of treatment, the doctor should request a written statement signed by the patient in the presence of a witness. The doctor should give the patient full information as to the likely benefits of medication, possible therapeutic alternatives, and warn him/her about risks associated with his/her refusal. It should be ensured that the patient has a full understanding of his/her situation. If there are difficulties of comprehension due to the language used by the patient, the services of an experienced interpreter must be sought.
>
> 61. The clinical assessment of a hunger striker should be carried out only with the express permission of the patient, unless he or she suffers from serious mental disorders which require the transfer to a psychiatric service.
>
> 62. Hunger strikers should be given an objective explanation of the harmful effects of their action upon their physical well-being, so that they understand the dangers of prolonged hunger striking.
>
> 63. If, in the opinion of the doctor, the hunger striker's condition is becoming significantly worse, it is essential that the doctor reports this fact to the appropriate authority and takes action in accordance with national legislation (including professional standards).

The Recommendation states that clinical assessment of competent hunger strikers may only be carried out with their consent. It also underlines that the hunger striker must be fully and objectively informed on all the aspects of the hunger

strike. Although the Preamble refers to the specific declarations of the WMA concerning medical ethics, in particular the Declarations of Tokyo and Malta, the Recommendation does not go into the question of force-feeding. Article 63 indicates that the issue of intervention in hunger strikes is left to national legislation, which includes professional standards for physicians.

3.2. EPR AND FORCE-FEEDING PRISONERS AND DETAINEES ON HUNGER STRIKE

A second Recommendation of the Council of Europe on the treatment of prisoners is the Recommendation on the EPR.[71] The scope of the EPR is different from that of Recommendation Concerning the Ethical and Organisational Aspects of Health Care in Prison. In Rule 10.1, prisoners are defined as "persons who have been remanded in custody by a judicial authority or who have been deprived of their liberty following conviction". These persons should, according to Rule 10.2 "only be detained in prisons, that is, in institutions reserved for detainees of these two categories". The commentary to Rule 10 of the EPR acknowledges that the terminology of a "prison" varies from country to country. Custodial institutions of various kinds, such as penitentiaries and work colonies, may also hold prisoners and may therefore be regarded as prisons for the purpose of these Rules. Alongside remand prisoners or sentenced offenders in prisons, other groups of persons can be held by virtue of provisions in national law. This is the case with, for example, immigration detainees. If these persons are detained in prisons, they are to be treated as prisoners in terms of these Rules, although the commentary to the EPR notes that a prison by definition is not a suitable place for persons who are neither suspected nor convicted of a criminal offence.[72] It can be concluded that the term "prisoner" in the EPR covers not only prisoners as defined in this study, but can also include detainees. In discussing the EPR below, I will use the term prisoner, but it should be noted that this group can also include detainees as defined in this research.

As with Council of Europe's Recommendation Concerning the Ethical and Organisational Aspects of Health Care in Prison, this Recommendation is not binding on Member States. However, it is evidence of an awareness of the rights of persons in custody.[73] The EPR contain stipulations on how persons who are deprived

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71 Council of Europe, Recommendation Rec(2006)2 of the Committee of Ministers to member states on the European Prison Rules (adopted by the Committee of Ministers on 11 January 2006 at the 952nd meeting of the Ministers' Deputies).

72 Commentary to Council of Europe's Recommendation Rec(2006)2 of the Committee of Ministers to member states on the EPR.

73 Also, they are not completely free of engagement, since they were drafted by the Committee of Ministers, comprised of the Foreign Affairs Ministers of all the Member States, or their permanent diplomatic representatives in Strasbourg.

of their liberty should be treated. The EPR can be seen as the Council of Europe's equivalent of the UN SMR.

As with the UN SMR, the EPR do not contain stipulations on hunger strike and only pay attention to the use of force and instruments of restraint. Rule 64.1 states that "[p]rison staff shall not use force against prisoners except in self-defence or in cases of attempted escape or active or passive physical resistance to a lawful order and always as a last resort". Furthermore, the amount of force shall be the minimum necessary and shall be used for the shortest necessary time (Rule 64.2), reflecting the principles of proportionality and subsidiarity. According to Rule 68, the use of chains and irons is prohibited. The second paragraph of this Rule determines that handcuffs, restraint jackets and other body restraints may not be used, except as a precaution against escape during a transfer and by order of the director, if other methods of control fail, in order to protect a prisoner from self-injury, injury to others or to prevent serious damage to property, provided that in such instances the director immediately informs the medical practitioner and report to the higher prison authority. The third paragraph of Rule 68 adds that instruments of restraint shall not be applied for any longer than is strictly necessary. Although feeding against the will of a prisoner always requires force to restrain him, it can be doubted whether the principles concerning the use of force are equally applicable to force-feeding, as this issue is not addressed in the EPR.

3.3. BIOMEDICINE CONVENTION[74] AND FORCE-FEEDING PRISONERS AND DETAINEES ON HUNGER STRIKE

Article 4 of the Biomedicine Convention is about the issue of professional standards, and states that "[a]ny intervention in the health field, including research, must be carried out in accordance with relevant professional obligations and standards". The Explanatory Report explains that the term "intervention" must be understood here in its widest sense, as covering all medical acts, in particular interventions performed for the purpose of preventive care, diagnosis, treatment or rehabilitation or in a research context.[75] Articles 5-9 deal with consent (see Ch. 2, § 8.4). According to the Biomedicine Convention, all interventions in the health field require informed consent. This is the only determinant for the application of medical treatment. On the basis of the Biomedicine Convention, forced medical treatment, including force-feeding, even when in the best interests of the patient, is not permitted.

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74 Council of Europe, Convention for the protection of human rights and dignity of the human being with regard to the application of biology and medicine: convention on human rights and biomedicine. Oviedo (ETS No. 164), 4 April 1997.

75 Explanatory Report to the Biomedicine Convention, under 29.

3.4. THE ECOMHR AND ECTHR AND PRISONERS AND DETAINEES ON HUNGER STRIKE

The ECHR contains three articles that are relevant in assessing force-feeding prisoners on hunger strike: Articles 2, 3 and 8.[76] As stated in Ch. 2, § 8.1, two bodies were originally established to ensure the rights and freedoms laid down in the ECHR: the EComHR and the ECtHR. The EComHR and ECtHR have ruled on hunger strikes in many cases, concerning both prisoners and detainees. In discussing the cases, I will use the terminology that is used by the EComHR or ECtHR in the ruling. Although the EComHR and ECtHR only use the term "prisoner" and "detainee" in these specific cases, in my opinion, the considerations by the EComHR and ECtHR apply equally to all those deprived of their liberty.

Below, I will only deal with cases that directly concern the issue of force-feeding, or cases that contain considerations which are relevant for the assessment of the legitimacy of force-feeding. In the following, I will outline the development of the views by the EComHR and ECtHR by describing and discussing ten remarkable cases by the two bodies in chronological order.

3.4.1. 1977 EComHR Gallagher v the Netherlands[77]

The case of *Gallagher v the Netherlands* does not deal with the issue of force-feeding, but with the extradition of a hunger striker. The applicant complained that the Netherlands, by the very intention to extradite and transport him at a moment when his life was in danger, had treated him in a way that was inhuman and/or degrading. The EComHR first noted that "whatever the applicant's state of health might have been shortly before and at the moment of his extradition, it had been brought about by the applicant himself by his own hunger- and thirst-strike". The EComHR clearly stated here that the deteriorated state of health of the hunger striker was the result of his own decision to go on hunger strike; he alone is responsible for his own deteriorated state of health. The EComHR furthermore noted that "[o]f course it should be understood that, even in these circumstances, every act by the Dutch authorities which would have had a direct bearing upon the applicant's physical condition and present a threat to his life could be contrary to the Convention, in particular to Arts. 2 and 3 thereof". In other words: although the hunger striker had brought himself into this position, the authorities had to abstain from measures that would deteriorate his condition. In the present case, a medical report showed that transport to Ireland would physically still be possible. That such transport might break the applicant's spirit and could lead

[76] For an elaboration on the positive obligations on the basis of Article 2 ECHR, see Ch. 3, § 2.2.2; for an elaboration on Articles 3 and 8 ECHR in the protection of prisoners and detainees against forced medical treatment, see Ch. 3, § 6.2.2.

[77] EComHR 15 December 1977, *Gallagher v the Netherlands,* App. No. 8088/77.

to a deterioration of his state of health was not a sufficient reason in the eyes of the EComHR to conclude that the handling of the case by the Dutch authorities could not be considered treatment contrary to Article 3, especially since it appeared that when in Ireland the hunger striker had ended his hunger and thirst strike and had again started to eat. Although not concerned with force-feeding, this case showed that the EComHR emphasises the hunger striker's own responsibility, pointing out that the health consequences of a hunger strike were the result of the hunger striker's own decision to stop eating and/or drinking, and are at his own expense and risk.

3.4.2. 1984 EComHR R., S., A. and C. v Portugal[78]

In this case, the four applicants went on hunger strike to draw attention to their demands for an amnesty, to which they believed they were entitled on the grounds that they had committed political offences. After transfer to another prison, they were put under a stricter regime, and two of them where placed in a prison hospital. To ensure that the press was only informed of their state of health through official channels, the applicants refused to be examined by prison doctors and insisted on the presence of the doctor of their choice. After lengthy negotiations, when the state of three of them was deemed serious, the applicants were medically examined by a team composed of a doctor appointed by the Medical Council, a prison doctor and a doctor of their choice.[79]

As regards the applicants' complaints concerning the absence of medical care during their hunger strike, the EComHR noted that it was certainly disturbing that a long time had elapsed without the applicants being put under medical supervision. The question was, however, to what extent the national authorities were responsible for this situation. In this connection, the EComHR found it important to note that, as soon as they had begun their hunger strike, the applicants had always refused to be examined by the prison doctor. Moreover, two of them had refused to be examined by a team composed of three doctors they had listed as doctors of their choice.[80] The EComHR emphasised that "the Convention requires that the prison authorities, with due regard to the ordinary and reasonable requirements of imprisonment, exercise their custodial authority to safeguard the health and wellbeing of all prisoners, including those engaged in protest, in so far as that may be possible in the circumstances" The EComHR referred here to its 1980 ruling *McFeeley and Others v the United Kingdom*, where it had stated that, in a situation of protest "[t]he State is not absolved from its obligation under the Convention and Article 3 in particular, because prisoners are engaged in what is regarded as an unlawful challenge to the

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78 EComHR 15 March 1984, *R., S., A. and C. v Portugal*, App. Nos. 9911/82 & 9945/82, Decisions and Reports 36, pp. 200-208.

79 Ibid., p. 205.

80 Ibid., pp. 207-208, under 16.

authority of the prison administration" It furthermore added that, in situations of serious deadlock, authorities must not entrench themselves with an inflexible approach that is aimed at punishing offenders against prison discipline rather than at exploring ways of resolving the deadlock.[81]

The EComHR stated that the fact that the applicants had received no medical care for a long period during their hunger strike was regrettable, but that the applicants themselves were to a large extent responsible for this situation. In respecting the hunger strikers' refusal, the Portuguese Government had acted in a manner about which the applicants could not complain. It concluded that it was unable to conclude from the specific circumstances of the case that the authorities had shown inflexibility and had allowed the applicants' situation to deteriorate to the extent that they had been victims of inhuman treatment or torture violating Article 3 ECHR. Just as in *Gallagher v the Netherlands*, the EComHR emphasised the hunger strikers' own responsibility, not only for the physical harm they exposed themselves to, but also for consequences of other decisions they make during their strike, such as the refusal of treatment. By complying with such a wish, the authorities did not act in a manner about which applicants could complain.

Although these two cases seem to attribute great value to the hunger striker's own responsibility, and may indicate a plea for non-intervention in hunger strikes, neither explicitly go into the issue of active measures to intervene in the hunger strike, such as force-feeding. The case of *X v Germany* was the first case in which the EComHR specifically addressed the question of force-feeding prisoners and detainees on hunger strike.

3.4.3. 1984 EComHR X v Germany[82]

In this case, the applicant had been on hunger strike since his arrest and placement in prison. The prisoner was submitted to force-feeding twice a day, for three consecutive days. German law allowed such an intervention, and the necessary court permission was obtained to do so.[83] However, after a telephone conversation with the applicant's lawyer, the judge who had issued the arrest warrant ordered the applicant's immediate release. Before the EComHR, the applicant invoked Article 3 ECHR, complaining that he had been subjected to inhuman and degrading treatment in the period that he was force-fed. In an important passage, the EComHR noted that

> "[i]n the opinion of the Commission forced feeding of a person does involve degrading elements which in certain circumstances may be regarded as prohibited

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81 Ibid., p. 208, under 18, referring to EComHR 15 May 1980, *McFeeley and Others v the United Kingdom*, D&R. 20, p. 86.

82 EComHR 9 May 1984, *X v Germany*, App. No. 10565/83, 7 E.H.R.R. 135, pp. 152-154.

83 This policy had been changed. I will go into the German policy concerning prisoners and detainees on hunger strike in the next chapter.

> by Art. 3 of the Convention. Under the Convention the High Contracting Parties are, however, also obliged to secure to everyone the right to life as set out in Art. 2. Such an obligation should in certain circumstances call for positive action on the part of the Contracting Parties, in particular an active measure to save lives when the authorities have taken the person in question into their custody. When, as in the present case, a detained person maintains a hunger strike this may inevitably lead to a conflict between an individual's right to physical integrity and the High Contracting Party's obligation under Art. 2 of the Convention – a conflict which is not solved by the Convention itself."

The EComHR acknowledged that the main area of tension with force-feeding lay in the relationship between the Articles 2 and 3 ECHR. In general, Article 2 can call for positive action on the part of the State, even although the harm in this case was obviously self-inflicted. With this, the EComHR acknowledges that the State is under an obligation to safeguard the individual's life, even when the individual himself has caused the life-threatening situation, and adds that this duty to save lives is particularly stringent for people who have been taken into the State's custody, as they find themselves in a vulnerable position. The right to physical integrity and the State's obligations that arise from Article 2 come into conflict, especially when the hunger striker refuses to give up. The ECHR itself does not provide a solution to this problem.

In the present case, the EComHR found that German law provided the possibility to force-feed hunger strikers, if, as a result of their hunger strike, they would be subject to injuries of a permanent character. (Force-feeding was even obligatory if an obvious danger for the individual's life existed.) The assessment of these conditions is left to the doctor in charge, but an eventual decision to force-feed may only be carried out after judicial permission has been obtained. In this case, the EComHR observed that the doctor in charge had assessed that the applicant's situation necessitated force-feeding. The feeding was carried out by the use of the force necessary to overcome the applicant's resistance. The EComHR noted in this respect that it

> "is satisfied that the authorities acted solely in the best interests of the applicant when choosing between either respect for the applicant's will not to accept nourishment of any kind and thereby incur the risk that he might be subject to lasting injuries or even die, or to take action with a view to securing his survival although such action might infringe the applicant's human dignity."[84]

Furthermore, the measure of force-feeding was carried out during a relatively short period, and was taken with a view to securing the hunger striker's health or even saving his life. It did not subject the applicant to more constraint than necessary to

[84] EComHR 9 May 1984, *X v Germany*, App. No. 10565/83, 7 E.H.R.R. 135, p. 154.

achieve that goal. Accordingly, the EComHR concluded that the facts of the case did not disclose any appearance of a violation of Article 3 ECHR.

Obviously, also in this case, the hunger striker's individual right to physical integrity and obligations that arise from Article 2 come into conflict. Which interest prevails seems to be dependent on the circumstances of the case. In this case, German law (in the words of the EComHR) "solved" this issue because it stated that the turning point lies at the moment the hunger striker, as a result of his hunger strike, faces injuries of a permanent character or when the hunger strike becomes life-threatening. This means that, before the hunger striker faces injuries of a permanent character as a result of his hunger strike, the individual's physical integrity prevails and the prisoner or detainee may freely decide to begin and to continue his hunger strike. If the hunger strike continues and becomes health or even life-threatening, however, the State's obligation to safeguard the right to life as set out in Article 2 becomes predominant and dictates force-feeding. In this case, the EComHR agreed with the application of force-feeding to a prisoner to prevent injuries of a permanent character and was satisfied that the authorities acted "solely in the best interests of the applicant" by securing his survival through force-feeding. Force-feeding thus may be applied when motivated by reasons of the hunger striker's best interest. It should be noted, however, that this is not the best interest as pursued by the hunger striker, as he refuses nourishment of any kind, but the best interest of the hunger striker as pursued by the authorities. Acting in the hunger striker's best interest may thus lead to overruling the competent hunger striker's own express wishes (nothing in this case shows that the hunger striker concerned was incompetent or mentally ill). Williams criticises this case as an "alarming preference for paternalism at the expense of the article 8 right to private life".[85]

3.4.4. 1992 ECtHR Herczegfalvy v Austria[86]

This case concerns Herczegfalvy, a mentally ill prisoner, who, during his imprisonment repeatedly went on hunger strike to protest, *inter alia*, against his detention and the refusal of the authorities to give him his files. When he went on hunger strike for the first time, he collapsed after 26 days of striking and was transferred to a clinic where he received intensive medical care. Afterwards, he returned to a Viennese psychiatric hospital, where he was force-fed because of his weak state as a result of his food refusal. He stopped his hunger strike after being allocated a single room and being given some of the files that he had demanded. However, after a couple of months, he went on hunger strike for the second time and he allegedly eventually agreed to be fed through a tube once daily. Herczegfalvy later denied that this consent

[85] Williams 2001, p. 292.

[86] ECtHR 24 September 1992, *Herczegfalvy v Austria,* App. No. 10533/83.

had been validly given. After this hunger strike, he used hunger strikes as a means of protest over a period of time, and he was again fed, partly at his own request.

Before the ECtHR, Herczegfalvy complained of his medical treatment and alleged that Article 3 had been violated as he had been forcibly administered food and neuroleptics, and was isolated and handcuffed to a security bed during his second hunger strike. In this case, the ECtHR stated that "the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with". This especially applies for Article 3, which is formulated in absolute terms and permits no derogation. If the physical and mental health of patients have to be preserved, if necessary by force, "[t]he established principles of medicine are admittedly in principle decisive […]; as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading. The Court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist."[87] In the present case, in the ECtHR's view, it was above all the length of time during which the handcuffs and security bed were used when force-feeding the applicant during his second hunger strike, which appeared to be worrying. However, the ECtHR considered the evidence of the applicant not sufficient to disprove the Austrian Government's argument that medical necessity justified the treatment in issue. Accordingly, no violation of Article 3 was shown.

This case suggests that measures which are therapeutically necessary cannot be regarded as inhuman or degrading. Whether measures are therapeutically necessary is left to the medical authorities to decide on the basis of the recognised rules of medical science, according to the ECtHR. Compulsory medical treatment of mentally ill patients who cannot make rational decisions about their own treatment is permitted, but States have to be able to show that any particular course of treatment was medically necessary. Measures of therapeutic necessity could include force-feeding, as in the present case. Although the *Herczegfalvy* case provides some clarity in the discussion on force-feeding by emphasising the importance of the medical necessity of measures to intervene in hunger strikes, in my opinion, it remains difficult to draw conclusions from this case for various reasons. First, this case concerned a mentally ill prisoner. Whether the rules from this case are equally applicable to competent hunger strikers can be seriously doubted. Secondly, the considerations of the ECtHR do not specifically refer to force-feeding, but strongly pertain to the other measures that were applied, such as the forcible administration of neuroleptics, the measure of isolation, and the attachment to a security bed with handcuffs. In the assessment of the circumstances of the specific case, the ECtHR was only explicit on the length of the application of the handcuffs and the security bed. The question of the legitimacy of force-feeding competent prisoners and detainees on hunger strike therefore remained unanswered by the ECtHR in this case.

[87] Ibid., paragraphs 82-84.

3.4.5. 1997 EComHR Ilijkov v Bulgaria[88]

Ilijkov started a hunger strike whilst detained on remand, demanding his release on bail. He agreed to the administration of an intravenous infusion. After he refused another intravenous infusion, the director of the prison consulted a prosecutor over the telephone and authorised a medical commission of three doctors to administer artificial feeding if necessary. When the medical commission examined the applicant for the eighth time since the beginning of his strike, it found that the hunger striker's condition had deteriorated, but that he was still capable of understanding the consequences of his acts and that he firmly wanted to continue his strike. With a view to preserving the hunger striker's health, the medical commission administered force-feeding. Despite this force-feeding, the hunger striker's state of health on the twenty-seventh day of his strike was found to be dangerous for his life. The applicant was therefore brought to a hospital, where he continued to be force-fed. When he returned to prison, Ilijkov wrote a statement that he was aware of the fatal consequences of his acts, but insisted not to be force-fed. However, the force-feeding continued, because the prison doctor considered that its suspension would endanger the hunger striker's health. Finally, after 67 days of hunger striking, Ilijkov decided to suspend his hunger strike and resumed eating and drinking.

The applicant complained before the EComHR that he had been subjected to torture and inhuman and degrading treatment contrary to Article 3 ECHR. More specifically, he claimed that the force-feeding during his hunger strike had been administered by unqualified personnel through a dirty rubber hose, in a manner which caused violent pain and a sense of helplessness and represented a serious risk to his life. In dealing with this complaint, the EComHR first reiterated the rule from *Herczegfalvy*: "a measure which is a therapeutic necessity from the point of view of established principles of medicine cannot in principle be regarded as inhuman and degrading. The Convention organs must nevertheless satisfy themselves that the medical necessity has been convincingly shown to exist." The EComHR acknowledged that Ilijkov did not so much complain about the fact that he had been subjected to force-feeding, but about the way in which he had been force-fed: "the applicant does not claim that he should have been left without any food or medicaments regardless of the possible lethal consequences. Consequently, the applicant does not claim that the forced feeding per se, as an act of disrespect for his will to continue the hunger strike, amounted to torture and inhuman and degrading treatment contrary to Article 3." For this reason, the EComHR only investigated whether the manner in which the applicant had been force-fed and treated in general during the hunger strike had violated Article 3 ECHR. For this reason, the EComHR (again) does not provide us with an answer to the question of the force-feeding of a competent hunger striker (who in this case had even

[88] EComHR 20 October 1997, *Ilijkov v Bulgaria,* App. No. 33977/96.

signed a declaration of non-intervention). In going into the facts of the case, the EComHR noted that the applicant's statement that he had been fed by unqualified personnel through a dirty rubber hose was not supported by the medical reports. It concluded that the force-feeding aimed at preserving the hunger striker's life, and was decisive in the fact that his health had not deteriorated. Also, the hunger striker was under constant medical supervision, and his medical treatment did not result in any deterioration of his health. The EComHR therefore did not consider Ilijkov to have been subjected to torture or inhuman and degrading treatment during the period of his hunger strike and declared the complaint inadmissible.

3.4.6. 2005 ECtHR Nevmerzhitsky v Ukraine[89]

Since 1977, the EComHR and ECtHR have both dealt with the issue of prisoners on hunger strike. Until 2005, they both refrained from taking a stance on the principal matter of the permissibility of force-feeding competent prisoners and detainees on hunger strike. This changed in 2005 when the ECtHR ruled in a landmark case concerning this topic: *Nevmerzhitsky v Ukraine*.

Nevmerzhitsky, a Ukrainian national, was detained from 8 April 1997 to 22 February 2000 in the Kyiv Region Temporary Investigative Isolation Unit. He was charged with, *inter alia*, theft, the making of unlawful currency transactions, tax evasion, and fraud and forgery committed by an official. He went on hunger strike on 13 April 1998, consuming only water. On 17 April, his medical condition was examined, and he was subjected to force-feeding as of 23 April 1998. Nevmerzhitsky suspended his hunger strike on 14 July 1998, only to resume it again in October 1998. On 1 December 1999, the doctor of the detention facility issued a statement that the hunger striker was receiving medical treatment and, because of his continuing hunger strike, was being force-fed. The applicant continued his hunger strike and, between 10 January and 7 February 2000, he was examined by a doctor on eighteen occasions. According to the applicant, his last hunger strike lasted from 5 October 1998 to 23 February 2000. Relying on Article 3 ECHR, the applicant stated that he had been deprived of adequate medical treatment while on remand and complained of poor detention conditions. Furthermore,

> "[t]he applicant alleged that he had been force-fed while on hunger strike, without any medical necessity being established by the domestic authorities, which had caused him substantial mental and physical suffering. In particular, he alleged that he had been handcuffed to a heating appliance in the presence of guards and a guard dog (in his further complaints he did not mention the guard dog), and had been held down by the guards while a special medical tube was used to feed him."

[89] ECtHR 5 April 2005, *Nevmerzhitsky v Ukraine,* App. No. 54825/00.

Before going into the facts of the case, the ECtHR stated its general principles as enshrined in the case law in paragraphs 79-81. First, the ECtHR reiterated that Article 3 ECHR "enshrines one of the most fundamental values of a democratic society. It prohibits in absolute terms torture or inhuman or degrading treatment or punishment, irrespective of the circumstances and the victim's behaviour."[90] I already discussed relevant case law concerning Article 3 ECHR in Ch. 3, § 6.2.2.1, but as Article 3 ECHR plays a crucial role here, I will repeat the main considerations on Article 3 as outlined by the ECtHR.

As established in previous case law, the ECtHR reiterated that "ill-treatment must attain a minimum level of severity if it is to fall within the scope of Article 3 ECHR. The assessment of this minimum level is relative, and depends on all the circumstances of the case, such as the duration of the treatment, its physical and mental effects and, in some cases, the sex, age and state of health of the victim."[91] Furthermore, the ECtHR reiterated that the suffering and humiliation involved must in any event exceed the inevitable element of suffering or humiliation connected with a legitimate deprivation of liberty.

> "Nevertheless, in the light of Article 3 of the Convention, the State must ensure that a person is detained under conditions which are compatible with respect for human dignity, that the manner and method of the execution of the measure do not subject the individual to distress or hardship exceeding the unavoidable level of suffering inherent in detention, and that, given the practical demands of imprisonment, the person's health and well-being are adequately secured […] with the provision of the requisite medical assistance and treatment […]. When assessing conditions of detention, account has to be taken of the cumulative effects of these conditions, as well as the specific allegations made by the applicant […]."[92]

The ECtHR noted that the applicant's complaints under Article 3 ECHR mainly concerned three issues. First, whether the conditions of the applicant's detention were compatible with that provision. Secondly, whether the applicant's force-feeding while he was on hunger strike amounted to inhuman or degrading treatment or punishment or torture. Thirdly, whether the applicant was provided with the necessary medical treatment and assistance while being held in detention and while on hunger strike. Below, I will only deal with the applicant's second and third complaints.

In dealing with the second complaint, the ECtHR showed that it had due regard to the previous cases as dealt with by the EComHR concerning force-feeding prisoners and detainees on hunger strike, which I discussed above. As with the EComHR (in *X v Germany*), the ECtHR acknowledges that "forced-feeding does

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90 Ibid., paragraph 79.

91 Ibid., paragraph 80.

92 Ibid., paragraph 81, with references.

involve degrading elements which in certain circumstances may be regarded as prohibited by Article 3 of the Convention". Still, the ECtHR also acknowledges that hunger strikes "may inevitably lead to a conflict between an individual's right to physical integrity and the High Contracting Party's positive obligation under Article 2 of the Convention – a conflict which is not solved by the Convention itself". The ECtHR also refers to the ruling of the EComHR in its 1997 case of *Ilijkov v Bulgaria*, in which the EComHR declared the hunger striker's allegations of being subjected to ill-treatment through force-feeding unsubstantiated, as the applicant had failed to prove that the manner of his force-feeding amounted to torture or inhuman or degrading treatment or punishment. Finally, the ECtHR mentioned that, besides the decisions of the EComHR, it also had due regard to the Recommendations of the Committee of Ministers (see Ch. 5, § 3.1 and 3.2) and the reports of the CPT (see Ch. 5, § 3.5) and the Declarations of Tokyo and Malta of the WMA (see Ch. 5, § 2.2.1 and 2.2.2) in respect of the force-feeding of detainees.

In a key passage, paragraph 94, the ECtHR reiterated its 1994 *Herczegfalvy* ruling, that "a measure which is of therapeutic necessity from the point of view of established principles of medicine cannot in principle be regarded as inhuman and degrading", but added that

> "[t]he same can be said about force-feeding that is aimed at saving the life of a particular detainee who consciously refuses to take food. The Convention organs must nevertheless satisfy themselves that the medical necessity has been convincingly shown to exist […]. Furthermore, the Court must ascertain that the procedural guarantees for the decision to force-feed are complied with. Moreover, the manner in which the applicant is subjected to force-feeding during the hunger strike shall not trespass the threshold of a minimum level of severity envisaged by the Court's case law under Article 3 of the Convention. The Court will examine these elements in turn."

In this passage, the ECtHR states that force-feeding of detainees on hunger strike cannot be regarded as inhuman and degrading within the meaning of Article 3, if

a) the medical necessity has been convincingly shown to exist;

b) the procedural guarantees for the decision to force-feed are complied with; and

c) the manner in which the applicant is subjected to force-feeding does not transgress the threshold of a minimum severity as envisaged by Article 3 ECHR.

Before the ECtHR examined these criteria in paragraphs 95-99 it noted that "the applicant did not claim that he should have been left without any food or medicine regardless of the possible lethal consequences". The applicant only claimed that

there had been no medical necessity to force-feed him, and the force-feeding was used to humiliate and punish him, and to make him stop his hunger strike. This is an important remark, since this means that the ECtHR in this case explicitly did not intend to pronounce on the question of whether the prisoner should have been left without food, in other words, whether his wish for non-intervention should have been respected or not. For this reason, the ECtHR does not provide us with an answer to the fundamental question on the relation between the individual's right to physical integrity and right to self-determination, and a possible right to intervention on the part of the State as concerns the principal question of the legitimacy of force-feeding prisoners on hunger strike. Still, this case is important for this question, as the ECtHR declared that, if the three criteria formulated are complied with, force-feeding can stand the test of Article 3 ECHR. In my opinion, in this way the ECtHR in fact – although indirectly – has answered the question of whether prisoners on hunger strike must be left without food, or intervention through the use of force-feeding can be justified.

In going into the circumstances of the specific case, the ECtHR first of all observed that the Ukrainian Government had not provided the documents by the domestic authorities to demonstrate that there was a medical necessity to force-feed the applicant as required by the Decree of the Ministry of Internal Affairs of 4 March 1992 concerning force-feeding of prisoners on hunger strike. As the Ukrainian Government could not demonstrate that the force-feeding was medically necessary, the ECtHR could only assume that it had been arbitrary. It furthermore added that, in this case, procedural safeguards had not been respected in the face of the applicant's conscious refusal to take food when force-feeding was imposed on him either. The ECtHR concluded by stating that "[a]ccordingly, it cannot be said that the authorities acted in the applicant's best interest in subjecting him to force-feeding".

The ECtHR ruled that the Decree of the Ministry of Internal Affairs of 4 March 1992 concerning force-feeding of prisoners on hunger strike requires a medical necessity before force-feeding can be applied, by determining that

> "The force-feeding of a detainee on hunger strike shall be a measure of last resort aimed at preserving life and may only be used where the educational work and other measures of influence have had no effect on the detainee, and his/her further refusals to take food are endangering his/her life.
>
> The decision to force-feed shall be adopted by the head of the institution, or the person acting on his behalf, on the basis of a written report by the medical commission establishing a life-threatening decline in the state of health of a detainee on hunger strike."[93]

[93] Under Section 1.9 of the Decree of the Ukrainian Ministry of Internal Affairs of 4 March 1992 concerning force-feeding of prisoners on hunger strike, as quoted in ECtHR 5 April 2005, *Nevmerzhitsky v Ukraine,* App. No. 54825/00, paragraph 62.

Both the EComHR and the ECtHR acknowledge that there is a moment at which the prisoner's individual right to self-determination may be overruled, and intervention through force-feeding may be applied. Yet, the views of the two organs are different as to when this moment arrives. In this case, it seems to be when the hunger strike becomes life-threatening. This is different from the 1984 EComHR case of *X v Germany*, where the EComHR allowed intervention at the moment the hunger striker would be at risk of permanent damage to his health. It remains unclear in this case at what moment force-feeding would be allowed according to the ECtHR; only when the situation is life-threatening, or before this moment, when the hunger strike could cause injuries of a permanent nature.

In a case almost a year after *Nevmerzhitsky*, the *Wilkinson* 2006 case, the ECtHR provided some clarity on the question of medical necessity. In this case, concerning a patient with a mental disorder who contested the therapeutic necessity for a certain treatment, the ECtHR noted that "'medical necessity' is not limited to life-saving treatment", but it can also cover treatment, such as anti-psychotic medication, imposed as part of a therapeutic regime.[94] Here, it is made clear that medical necessity can exist before the situation is life-threatening. Nevertheless, "the decision as to what therapeutic methods are necessary is principally one for the national medical authorities: those authorities have a certain degree of interpretation in this respect since it is in the first place for them to evaluate the evidence in a particular case".[95] Accordingly, the ECtHR acknowledges that what therapeutic methods are, and a decision whether certain medical treatment is medically necessary, is principally for the national medical authorities. With regard to hunger strikes, in the case of *Nevmerzhitsky*, the ECtHR itself conformed to this medical judgment on the medical necessity, although it required that this medical necessity is substantiated and documented, by requiring that the medical necessity "has been convincingly shown to exist". On the basis of the cases of *Wilkinson* and *Nevmerzhitsky*, it can be concluded that in cases of prisoners and detainees on hunger strike, medical necessity is to be established by medical professionals and must be substantiated and documented, and the ECtHR accepts that such medical necessity can occur before the situation becomes life-threatening, for example when injuries of a permanent character occur (such as in the case of *X v Germany).*

Just as with previous cases, the ECtHR placed great value on the way the applicant was fed. In the present case, the ECtHR assumed that the applicant had been fed in the way prescribed by the Decree of the Ministry of Internal Affairs of 4 March 1992 concerning force-feeding of prisoners on hunger strike. According to the ECtHR, "in themselves the restraints that were applied – handcuffs, a mouth-widener […], a special rubber tube inserted into the food channel – in the event of resistance, with the use of force, could amount to torture within the meaning of Article 3 of

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94 ECtHR 28 February 2006, *Wilkinson v UK,* App. No. 14659/02 (decision on admissibility).

95 Ibid.

the Convention, if there is no medical necessity". In the instant case, the ECtHR finds that the force-feeding of the applicant, without any medical justification having been shown, using the equipment mentioned in the decree, and resisted by the applicant, constituted treatment of such a severe character warranting the characterisation of torture. In the light of all this, the ECtHR concluded that Article 3 ECHR had been violated.

The applicant's third complaint related to the fact that he had not been provided with the necessary medical treatment and assistance while being held in detention and while on hunger strike. The ECtHR noted its findings with regard to the force-feeding that was administered to the applicant, which in itself demonstrated that the Ukrainian authorities did not provide appropriate medical treatment, particularly not since the force-feeding was not shown to relate to his particular state of health or to the strict medical necessity of saving his life. Also, the applicant was not examined or attended by a doctor from 5 August 1998 to 10 January 2000. In the ECtHR's view, given the hunger strike and the diseases from which the applicant was suffering this cannot be deemed to be adequate and reasonable medical attention. Furthermore, the Government had provided no written records as to the force-feeding throughout the hunger strike, the kind of nutrition used, or the medical assistance provided to him in this respect. Beside an overall lack of adequate medical treatment and assistance during his detention, these circumstances constituted a violation of Article 3 ECHR as regards the lack of adequate medical treatment and assistance provided to the applicant while he was detained, amounting to degrading treatment.

3.4.7. 2007 ECtHR Ciorap v Moldova[96]

In a procedure before the ECtHR, Ciorap, a second degree invalid suffering from "mosaic schizophrenia", complained of the inhuman conditions of his detention in a remand centre. His complaints concerned, *inter alia*, the overcrowding in the cell, the presence of parasitic insects, the lack of proper ventilation and access to daylight, and a shortage of beds. In protest against these conditions, he periodically went on hunger strike. During these hunger strikes, he spent two periods of ten days in solitary confinement, apparently as a punishment for his refusal to take food. During his hunger strikes, he was force-fed on several occasions when his health was assessed to be deteriorating. His hunger strike lasted two months. The applicant argued that he had been force-fed without any medical necessity, and complained about the manner in which the force-feeding had been carried out. He further submitted that the force-feeding had a punitive character and had been primarily aimed at obliging him to stop his hunger-strike protest by subjecting him to severe pain and degrading treatment. Moreover, the manner in which it had been carried out caused him unnecessary pain and humiliation and did not offer

[96] ECtHR 19 June 2007, *Ciorap v Moldova,* App. No. 12066/02.

sufficient protection to his health. As a result, he had suffered a broken tooth and had contracted an abdominal infection.

In going into the alleged violation of Article 3 ECHR, the ECtHR referred to the general principles enshrined in the case law in respect of force-feeding as shown in paragraphs 79-81 of *Nevmerzhitsky*. In assessing the facts of the case to determine whether force-feeding could stand the test of Article 3 ECHR in this specific case, it used the criteria as in the 2005 *Nevmerzhitsky* case. In this case, however, the ECtHR only examined the medical necessity to force-feed the applicant, and the manner of force-feeding of the applicant.

Concerning the medical necessity, the ECtHR noted that the two ten-day isolation periods reflected the applicant's hunger strike as being considered by the prison authorities to be violations of the rules and acts of disobedience towards the prison administration, which suggested that the force-feeding was not aimed at protecting his life but rather as discouraging further protest. It added that the applicant had never been in danger during hunger strikes in the past, and had never been force-fed. This supports the applicant's claim that his force-feeding was not aimed at protecting his life, but was mainly used to discourage him from continuing his protest. Further inconsistencies in the Government's case supported this view. For example, force-feeding was urged for the applicant's condition, while he was still considered sufficiently fit to attend court hearings. There was insufficient evidence of a medical necessity before the force-feeding was initiated. In view of the lack of medical evidence that the applicant's life or health necessitated force-feeding, the ECtHR noted that "it cannot be said that the authorities acted in the applicant's best interest in subjecting him to force-feeding, which of itself raises an issue under Article 3 of the Convention". With this last statement, the ECtHR underlined the importance of the criterion of medical necessity, as formulated by the ECtHR in the *Nevmerzhitsky* case. Moreover, the question of whether the force-feeding was applied in the best interests of the hunger striker here is dependant on the question of whether a medical necessity existed at the time of force-feeding. By doing so, the ECtHR objectified the criteria to assess whether the force-feeding was applied in the best interest of the hunger striker, moving away from the more paternalistic approach as employed by the EComHR in the case of *X v Germany* as described in § 3.4.7.

The ECtHR noted that it was struck by the manner of the force-feeding in the present case. The applicant described this process by stating that

> "he was always handcuffed, even though he never physically resisted force-feeding but simply refused to take food as a form of protest. The prison staff forced him to open his mouth by pulling his hair, gripping his neck and stepping on his feet until he could no longer bear the pain and opened his mouth. His mouth was then fixed in an open position by means of a metal mouth-widener. His tongue was pulled out of his mouth with a pair of metal tongs which he claims left it numb and bleeding each time. A hard tube was inserted as far as his stomach through which liquidised food passed into his stomach provoking, on some occasions, sharp pain. When the

> metal holder was removed from his mouth, he bled, he could not feel his tongue and was unable to speak. The instruments used for his force-feeding were not fitted with single-use, soft protection layers to prevent pain and infection."

Also, a number of procedural guarantees prescribed by domestic law (such as clarifying the reasons for starting and ending the force-feeding) were only partly observed if at all. Also, less intrusive alternatives, such as an intravenous drip, had not even been considered, despite the applicant's express request. The ECtHR concluded that the manner in which the force-feeding was carried out had been unnecessarily painful and humiliating.

In light of all this, the ECtHR concluded that the applicant's repeated force-feeding had not been prompted by valid medical reasons but had rather been aimed at forcing him to stop his protest. Furthermore, it was performed in a manner that unnecessarily exposed him to great physical pain and humiliation that could only be considered as torture. Accordingly, the ECtHR ruled (unanimously) that Article 3 ECHR had been violated.

3.4.8. 2009 ECtHR Horoz v Turkey[97]

In 1999, Muharrem Horoz (the applicant's son) was arrested in Istanbul and placed in pre-trial detention suspected of various terrorist acts. In 2001, he joined a hunger strike in the Kandira F-type prison, in protest against the introduction of these prisons. This fast soon became a death fast, during which the hunger strikers only took sugared water and vitamins. During the strike, Muharrem Horoz was transferred to a civil hospital several times; on one occasion he had lost consciousness. After being resuscitated, he refused all further intervention. The Institute of Forensic Medicine (*l'Institut médicolégal*) diagnosed a "terminal failure as a result of insufficient nutrition, and recommended his release for six months, as his health was incompatible with imprisonment". His lawyer filed an application for his release, which was denied by the National Security Court (*le cour de sûreté de l'Etat*), as such a release on health grounds was only possible for convicted persons, and not for pre-trial detainees, and that his health care could be provided in a civil hospital. Two days later, Muharrem Horoz died in a civil hospital as a result of his hunger strike. Before the ECtHR, the mother of Muharrem Horoz complained that the authorities were responsible for the death of her son, as they had refused to release him on health grounds. In cases of force-feeding normally, as we have seen in the cases discussed above, the legal conflict evolved around Articles 2 and 3 ECHR. As intervention was absent in this case, the applicant only invoked Article 2 ECHR, the right to life.

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[97] ECtHR 31 March 2009, *Horoz v Turkey,* App. No. 1639/03 (available in French only).

The ECtHR decided that, although the Institute of Forensic Medicine had recommended the release of Muharrem Horoz and it would have been desirable for him to be released as a result, it found no evidence to criticise the authorities' assessment of the information in the report. Furthermore, the ECtHR could substitute its own judgment for that of the domestic court, especially since the authorities had satisfied their obligation to protect the physical integrity of the hunger striker by providing him with the necessary medical treatment. In this context, the authorities could not be blamed for having respected the refusal of any intervention by Muharrem Horoz, even when his state of health was life-threatening. Moreover, there was no evidence that he was deprived of treatment in prison that he could have received had he been released from prison. For this reason, the ECtHR could not establish a causal relationship between the denial for the hunger striker's release and his death. The ECtHR concluded that Article 2 ECHR had not been violated.

According to the ECtHR, States are obliged to provide hunger strikers with the necessary medical treatment. However, they are not responsible under Article 2 ECHR when they respect the hunger striker's wishes and the hunger striker subsequently dies as a result of his action. In my opinion, it can be concluded that no positive obligation exists for States and State authorities to actively intervene in a hunger strike through the use of force-feeding on the basis of Article 2 ECHR.

3.4.9. 2009 ECtHR Pandjikidze and Others v Georgia[98]

In 1999, the Georgian Security Ministry decided to prosecute a group that was suspected of plotting to overthrow the incumbent regime. In 2001, the applicants were sentenced to imprisonment for plotting against the regime. The applicants appealed against this decision, but this appeal was dismissed. One of the applicants went on a 115-day hunger strike while being held in pre-trial detention to register his disagreement with the criminal proceedings against him. Concerning this hunger strike, the ECtHR stated that the applicant had never been force-fed by the authorities (unlike in *Nevmerzhitsky*) and he had not complained to the ECtHR that the authorities should have taken such action. Even though his state of health must have declined, it did not appear from the case file that his life had been exposed to an obvious danger as a result of the authorities' attitude, and therefore that force-feeding would have been justified by any "medical imperative", or that he had been deprived of medical treatment appropriate to his state of health, or that he had been medically unfit to remain in prison. Therefore, the ECtHR declared the applicant's complaint manifestly ill-founded.

[98] ECtHR 27 October 2009, *Pandjikidze and Others v Georgia*, App. No. 30323/02 (decision on admissibility, available in French only).

3.4.10. 2010 ECtHR Dermanović v Serbia[99]

On 24 March 2003, a criminal investigation was opened against Dermanović, a Serbian citizen suspected of abuse of power and forging of official documents. Because of a risk of flight, he was detained on remand. He filed several applications for release on bail, but his requests were dismissed. In the period 2004-2007, the applicant was sentenced to imprisonment twice, but both these judgments were quashed by the Supreme Court. Finally, in June 2007, this court sentenced the applicant to four years' imprisonment, but decided to release him. However, he was ordered not to leave his habitual place of residence and report to the court each month. During his detention, he suffered from psychiatric problems, severe back pain, and was hospitalised as a result of a hunger strike. At the end of 2006, the applicant was diagnosed with hepatitis C during voluntary testing and counselling for hepatitis and HIV. On 25 January 2007, the applicant went on hunger strike. As a result of his hunger strike on 1 March 2007, he was transferred to a prison hospital. There he refused to be examined by the hospital staff, claiming that he had contracted hepatitis during his last stay there. At his own request, he was transferred back to the prison. On his return, he was examined by a medical specialist, who concluded that he should undergo a liver biopsy, which was performed on 23 April 2007. The applicant was released from detention before he started receiving further treatment for his condition.

Before the ECtHR, Dermanović complained that the treatment for his hepatitis C infection had been inadequate, as it had taken several months before he was examined for the first time by a specialist and his anti-viral treatment had not even begun prior to his release from detention seven months after the diagnosis. Moreover, during his hunger strike he had not been afforded the necessary vitamins, medication or tea.

In order to establish whether the applicant had received the requisite medical treatment, the ECtHR had to decide whether the State authorities had provided him with sufficient medical supervision for a timely diagnosis and treatment of his illnesses. The ECtHR noted that the applicant had discovered the hepatitis C infection during voluntary testing, and that there were no obvious earlier symptoms. For this reason, the ECtHR saw no evidence indicating that the authorities had failed to ensure prompt discovery of the infection. The applicant complained that once his illness had been diagnosed, he had not received prompt and adequate treatment. The ECtHR noted that chronic hepatitis is an illness that severely damages the liver and that an adequate assessment of the state of health is essential in order to be provided with adequate treatment. During the seven months between the applicant's diagnosis and release from detention, he had not started medication-based treatment for his hepatitis C infection, but had undergone a liver biopsy,

[99] ECtHR 23 February 2010, *Dermanović v Serbia*, App. No. 48497/06.

numerous blood tests and examinations by specialised doctors. Nevertheless, the ECtHR found it regrettable that two months had elapsed before the applicant was first examined by an infectious diseases specialist. However, the ECtHR noted "that, by going on a hunger strike and refusing to be examined in hospital, the applicant himself substantially delayed the identification of the damage to his liver which he had already sustained. In doing so, he showed little or no concern for his state of health and can therefore hardly hold the authorities responsible for the aggravation of his condition during that period."[100] The ECtHR concluded that the authorities had shown a sufficient degree of diligence, providing the applicant with prompt and uninterrupted medical care as well as the possibility of identifying the extent to which the disease had already progressed. It cannot be said that the authorities provided the applicant with inadequate or insufficient medical care. Accordingly, there had been no violation of Article 3 ECHR.

3.4.11. Conclusions

Since 1984, the EComHR and ECtHR have considered the question of the legitimacy of force-feeding in several cases. The EComHR went into the matter of force-feeding in the 1984 ruling of *X v Germany*, where it outlined the main tension that lies in the relationship between the Articles 2 and 3 ECHR. In this ruling, the EComHR determined that force-feeding involves degrading elements which, in certain circumstances, may be regarded as prohibited by Article 3 ECHR. The right to life of Article 2 ECHR, nevertheless, may call for active measures on the part of the State to save lives, especially when it concerns persons who the State has taken into their custody. With this, the EComHR presumes a large responsibility of the State for those that have been deprived of their liberty. This assumption was not only adopted by the EComHR, but also by the ECtHR, as it also assessed all cases of force-feeding in the context of Articles 2 and 3. Neither organ has elaborated on the roots or origins of this responsibility and they both seem to assume that, by depriving persons of their liberty, the State takes over full responsibility for them, which results in a strict obligation to safeguard their lives. This responsibility may be founded on the idea that prisoners and detainees constitute a vulnerable group that needs to be strongly protected, but does this obligation entail measures to safeguard the prisoner's or detainee's life, even if it is against his express wishes? Remarkably, the prisoner's or detainee's individual rights are mentioned nowhere (although their physical integrity is also safeguarded under Article 8).[101] When force-feeding is considered

[100] Ibid., paragraph 59.

[101] Although the EComHR in the 1984 case of *X v Germany* noted that a hunger strike can lead to a conflict between an "individual's right to physical integrity" and the State's positive obligations under Article 2 ECHR, the EComHR neither assessed the conformity of force-feeding of a competent hunger striker with Article 8 ECHR, nor elaborated on the prisoner's right involved in the matter.

as a measure to save the life of the prisoner or detainee, even against his express wishes, the right to life of Article 2 could easily be transformed into a *duty* to life for the prisoner or detainee involved. How does this relate to the ECtHR's view that human rights are still fully applicable to prisoners and are not inherently limited by imprisonment? This question remains unanswered by the EComHR and ECtHR.

Although they dealt with the question in several cases, the EComHR and ECtHR have, however, not answered the principal question of the legitimacy of force-feeding prisoners and detainees on hunger strike in their case law, even in the *Nevmerzhitsky* case, the 2005 landmark case which was largely devoted to the issue of force-feeding a competent prisoner on hunger strike. Still, this case is important regarding this question, as the ECtHR declared that, if the three criteria formulated are complied with, force-feeding can stand the test of Article 3 ECHR. In *Nevmerzhitsky*, the ECtHR determined that force-feeding that is aimed at saving the life of a hunger striker if it is medically necessary cannot in principle be regarded as inhuman and degrading. Nevertheless, the medical necessity must have been convincingly shown to exist, the procedural guarantees for the decision to force-feed have to be complied with, and the manner in which the applicant is subjected to force-feeding must not transgress the threshold of a minimum severity. If these three criteria are met, force-feeding in principle does not violate Article 3 ECHR, in the view of the ECtHR. In my opinion, in this way the ECtHR in the case of *Nevmerzhitsky* has answered, albeit indirectly, the question of whether prisoners on hunger strike must be left without food, or intervention through the use of force-feeding can be justified. Also, this case shows that the ECtHR is in principle not currently opposed to the force-feeding of prisoners on hunger strike.

Although *Nevmerzhitsky* has provided us with criteria to assess whether force-feeding can stand the test of Article 3 ECHR, it has also left us with a couple of questions. One of these concerns the relationship between the different criteria. Are they cumulative? Because of their formulation (using the terms "furthermore" and "moreover" in the enumeration), I think they are. In several cases prior to *Nevmerzhitsky*, the ECtHR had stressed the importance of both the medical necessity and the proper application of force-feeding, which does not include too much force. In *Nevmerzhitsky*, the ECtHR dealt separately with the two criteria of medical necessity and the manner in which the applicant was force-fed. This was the same in the 2009 case of *Horoz*. The criterion of the procedural guarantees that have to be followed was, *inter alia*, used by the ECtHR to investigate whether the medical necessity was shown to exist (in *Nevmerzhitsky*). With this, the ECtHR binds the government by its own rules.

Although in *X v Germany* and subsequent cases, the EComHR and ECtHR stated, and subsequently reiterated that the main issues for force-feeding hunger strikers in custody lie in Articles 2 and 3 ECHR, Article 8 ECHR can also be at issue. Yet, it remains unclear what role Article 8 ECHR plays in the discussion. Article 8 ECHR was invoked only in the case of *Herczegfalvy*. Herczegfalvy claimed that, by

administering food to him by force, the hospital authorities had violated Article 8 ECHR. In response, the ECtHR only noted that this complaint related "to facts already complained of from the point of view of Article 3". Moreover, the ECtHR considered that there was a lack of information disproving that the applicant's psychiatric illness has rendered him entirely incapable of taking decisions for himself.[102] Accordingly, the ECtHR did not check the applicant's force-feeding against Article 8 ECHR. The ECtHR may have considered Article 8 ECHR in *X v Germany*, but this case was only published in summarised form, so it remains unclear whether and, if so, in what way, the EComHR assessed Article 8 ECHR.[103]

In all the other cases discussed above, the applicants complained of a violation of Article 3, and the EComHR and the ECtHR only considered these cases in the context of Articles 2 and 3 ECHR. In my view, this can be explained by the fact that force-feeding demands severe medical intervention and always includes a substantial amount of force if the hunger striker does not cooperate. In the cases before 2005, the way the force-feeding was applied always played an important role in determining whether Article 3 ECHR had been violated. In *Nevmerzhitsky*, the ECtHR determined that the manner in which a person is subjected to force-feeding must not transgress the threshold of a minimum severity as envisaged by the ECtHR's case law under Article 3 ECHR. If this threshold of minimum severity is transgressed, the force-feeding can amount to inhuman and degrading treatment. Force-feeding can even qualify as torture, the most severe qualification of ill-treatment under Article 3, when administered in an excessive and brutal way, such as in the cases of *Nevmerzhitsky* and *Ciorap*.

But, what would happen if the force-feeding were applied in a less intrusive way, for example, through an intravenous drip? In the words of the ECtHR, this is "a less intrusive alternative" to force-feeding.[104] Assuming that the force-feeding is medically necessary and procedural guarantees are taken into account, the way of administration and the force used will be decisive in determining whether Article 3 has been violated. It is difficult to say what kind of treatment will be considered as transgressing the threshold of minimum severity as envisaged by the ECtHR's case law under Article 3 ECHR. The "living instrument doctrine" influences both the different terms used in Article 3 and the minimum level of severity. The ECtHR has repeatedly held that this threshold limit is in the nature of things, relative and depends on all the circumstances of the case, such as the duration of the treatment, its physical or mental effects and, in some cases, the sex, age, and state of health of the victim.

In my view, however, it may well be that if the minimum severity threshold of Article 3 ECHR is not exceeded, or the force-feeding meets the criteria as formulated

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102 ECtHR 24 September 1992, *Herczegfalvy v Austria,* App. No. 10533/83, paragraph 86.

103 As noted by Wijnakker, Wijnakker 2006, p. 443.

104 ECtHR 19 June 2007, *Ciorap v Moldova,* App. No. 12066/02, paragraph 87.

in *Nevmerzhitsky*, it could fall within the scope of Article 8 ECHR. In these cases, Article 8 ECHR could work as a safety net, providing protection against forced medical treatment, as covering the moral and physical integrity of a person (see Ch. 3, § 6.2.2.5). Under Article 8 ECHR, however, a wholly different assessment framework applies than for Article 3 ECHR, which is formulated in absolute terms and permits no derogation.

All of the cases I described above concerned active measures by the State and authorities of prisons and other places of detention, but what happens if the authorities respect the hunger striker's wish for non-intervention, and the hunger striker finally dies as a result of his action? Has the State then neglected its obligation to secure the right to life of those it has deprived of its liberty? In other words: does Article 2 ECHR constitute a positive obligation for States and State authorities to intervene in the hunger strike to preserve the health and life of the hunger striker? No, it does not, the ECtHR replied in the case of *Horoz*. States are obliged to take adequate care of persons who they have taken into their custody, according to Article 2 ECHR. Still, on the basis of Article 2, they are obliged to provide hunger strikers with the necessary medical treatment, but they are not responsible under Article 2 ECHR when they respect the hunger striker's wishes, and the hunger striker subsequently dies as a result of his action. It can be concluded that the positive obligations under Article 2 ECHR to take care of the prisoner's and detainee's health do not go so far as to call for measures on the part of the State to actively prevent the prisoner from dying as a result of his hunger strike through the use of force-feeding.

Above, I concluded that the ECtHR is not in principle opposed to force-feeding prisoners and detainees on hunger strike. Is this remarkable? I think it is not. In its case law, the ECtHR has developed criteria to determine whether force-feeding can stand the test of Article 3 ECHR in a specific case, but leaves it to States and their authorities to deal with this matter and to decide for themselves whether they will force-feed prisoners and detainees on hunger strike. As long as the *Nevmerzhitsky* criteria are met, force-feeding is acceptable, in the view of the ECtHR. States, however, may also decide to respect the hunger striker's wishes; they do not violate their obligations on the basis of Article 2 ECHR if they do not intervene in the hunger strike. It can be concluded that the ECtHR leaves a wide degree of interpretation for States to decide for themselves on how to deal with this matter. In my opinion, this attitude is a result of the fact that force-feeding is a delicate matter, a matter on which the opinions within the Member States of the Council of Europe strongly differ and little consensus exists between them. In a 1998 report on health care in prisons in Europe, the Council of Europe took note of these different approaches in Europe on force-feeding hunger strikers, and stated that

> "[h]unger strikes represent some of the biggest dilemmas that prison governors have to deal with from time to time.

> Some countries (for instance Finland) follow the WMA Tokyo Declaration: prisoners on hunger strike are informed of the consequences of their actions and their state of health is monitored; hospital treatment is arranged when needed (if the patient consents), advice is given on the importance of fluid intake. No treatment takes place when the prisoner refuses it.
>
> In other countries (Spain and Sweden) involuntary feeding may be given if, in the opinion of the physician, there is immediate danger for the life or the health of the patient. In some systems (like Italy) involuntary feeding is prohibited, unless the hunger striker is no longer able to be aware of the consequences of his refusal."[105]

It can be concluded that the Council of Europe has regard to the fact that there is no single, univocal "European approach" towards force-feeding. Both the ECtHR and the CPT struggle with finding a single response to hunger strikes within Europe, as will be shown below.

3.5. THE CPT AND FORCE-FEEDING PRISONERS AND DETAINEES ON HUNGER STRIKE[106]

In Ch. 3, § 2.2.4, I explored the task and mandate of the CPT. Below, I will investigate the opinion of the CPT on the issue as illustrated in the CPT Standards and its reports. I will also compare the views of the ECtHR and the CPT on the issue of force-feeding prisoners and detainees on hunger strike and draw conclusions.

As stated in Ch. 3, § 2.2.4, the CPT has largely devoted itself to the issue of health care in prisons and the medical treatment of prisoners in its Standards and reports, since it has acknowledged that adequate health care services in prisons are very important in the prevention of ill-treatment. There is no surprise here, given the CPT's composition. Unlike the ECtHR, the CPT consists not only of legal experts, but includes medical doctors and psychiatrists.[107] The second "substantive section" deals with the issue of health care services in prisons, and the CPT has dedicated several General Reports to it.[108] In the CPT Standards, the CPT consistently refers

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105 Council of Europe, Report on the Organisation of health care services in prisons in European member states, June 1998, under 4.6. Available at <http://www.coe.int/t/dg3/health/Prisonsreport_en.asp> (last accessed on 17 January 2012).

106 This part on the CPT and force-feeding prisoners and detainees on hunger strike, and the comparison with the view of the ECtHR, was already published in slightly different form as Jacobs 2010.

107 See Ch. 3, § 2.2.4. The same goes for the UN monitoring bodies.

108 The CPT has elaborated on the topic of health care in prison in, *inter alia*, its *3rd General Report,* CPT/Inf(93) 12, paragraphs 30-77, that contains general remarks on health care in prison. The CPT has also dedicated parts of reports to health care for specific categories of prisoners, such as women (CPT *10th General Report,* CPT/Inf(2000) 13, paragraphs 30-33) and juveniles (CPT *9th General Report*, CPT/Inf(99) 12, paragraphs 37-41).

to patients instead of prisoners to emphasise that a prisoner who needs medical care should be treated as any other patient. In section II on health care services in prisons the CPT underlines (paragraph II.45) that "[f]reedom of consent and respect for confidentiality are fundamental rights of the individual [which are essential in] the doctor/patient relationship, especially in prison, where a prisoner cannot freely choose his own doctor". Paragraph II.47 furthermore states that "[e]very patient capable of discernment is free to refuse treatment or any other medical intervention. Any derogation from this fundamental principle should be based upon law and should only relate to clearly and strictly defined exceptional circumstances which are applicable to the population as a whole."

A dilemma ensues, however, when the patient's decision conflicts with the general duty of care incumbent on the doctor. "This might happen […] when [the prisoner] is intent on using his body, or even mutilating himself, in order to press his demands, protest against an authority or demonstrate his support for a cause", for example, when he goes on hunger strike. In this regard, the CPT only mentions in paragraph III.47 that

> "[i]n the event of a hunger strike, public authorities or professional organisations in some countries will require the doctor to intervene to prevent death as soon as the patient's consciousness becomes seriously impaired. In other countries, the rule is to leave clinical decisions to the doctor in charge, after he has sought advice and weighed up all the relevant facts."

The CPT only indicates here that different countries think differently on the matter of preventing a hunger striker's death. On the issue of force-feeding, it does not commit itself; it does not pursue the fundamental question of whether intervention in a hunger strike is allowed or not. Probably, it follows here the approach taken by the ECtHR, that leaves a wide degree of interpretation to the States to decide on this matter themselves.

Although in the CPT Standards the issue of hunger strike is only mentioned in passing, several of its visit reports show that the treatment of prisoners on hunger strike is an area of concern. The CPT's findings in these reports can be summarised as follows. First of all, the CPT stresses the importance of a written protocol on hunger strikes and the development of appropriate hunger strike assessment and management programs.[109] Secondly, the CPT emphasises that hunger strikes should be approached from a therapeutic rather than a punitive standpoint. This last position was taken in a report on the mass hunger strike in Turkey against the introduction of the F-type prison system in 2000-2001. Until quite recently, this was the only

[109] Visit to the Netherlands (Aruba) in 2007, CPT/Inf(2008) 2, at 83, and visit to Sweden in 2009, CPT/Inf(2009) 34, at 87. Also: visit to Latvia in 1999, CPT/Inf (2001) 27, at 78.

report in which the CPT dealt with the issue of force-feeding prisoners on hunger strike. According to the CPT,

> "[…] the issue of the artificial feeding of a hunger striker against his/her wishes is a delicate matter about which different views are held, both within Turkey and elsewhere. […] To date, the CPT has refrained from adopting a stance on this matter. However, it does believe firmly that the management of hunger strikers should be based on a doctor/patient relationship. Consequently, the Committee has considerable reservations as regards attempts to impinge upon that relationship by imposing on doctors managing hunger strikers a particular method of treatment."[110]

As in the CPT Standards, the CPT states here that there are different views on force-feeding prisoners on hunger strike and that it refrains from adopting a stance on the matter. Yet, the CPT does seem to oppose the application of force-feeding, as it emphasises that the doctor/patient relationship should be the first priority. The CPT did not follow up on this topic, neither in public statements nor in its visit reports.[111] This changed when the CPT was involved in the hunger strike of the Spanish prisoner José Ignacio De Juana Chaos.[112]

In 2007, the CPT made an ad hoc visit to Spain to investigate the prolonged hunger strike and the force-feeding of De Juana. In its visit report, the CPT addressed the management of De Juana's hunger strike in general and the permissibility of the use of force-feeding in particular. The CPT noted that authorities involved in the management of a hunger strike are faced with two potentially conflicting values: their duty to safeguard a life, on the one hand, and the prisoner's right to physical integrity (including the right not to have treatment imposed upon him), on the other. In response to this dilemma, the CPT noted that "[i]t is not for the CPT to seek to resolve this conflict of values. The Committee's task is to examine whether, in practice, a person deprived of his liberty is at risk of being subjected to torture or inhuman or degrading treatment or punishment, irrespective of the position adopted by the authorities and doctors concerned."[113] The CPT (again) chose not to take a stance on the matter, but stated that its only task was to investigate whether, in a specific case, force-feeding constituted ill-treatment. To this end, the CPT only went into the aspects of this specific case in its report on De Juana's hunger strike.

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110 Visit to Turkey, in 2000 (December) and 2001 (May), CPT/Inf (2001) 31, at 33.

111 In a report on a visit to Austria in 2004, the CPT reiterated that hunger strikes should be approached from a therapeutic rather than a punitive standpoint; hunger strikers had been placed in segregation cells and subjected to a more restrictive regime than other detainees, CPT/Inf (2005) 13, at 51. In a report on a visit to Armenia in 2002, the CPT stated that vulnerable prisoners such as hunger strikers "should never be accommodated under material conditions which are inferior to those prevailing on normal locations", Armenia visit 2002, CPT/Inf (2004) 25, at 74.

112 Visit to Spain from 14 to 15 January 2007, CPT/Inf (2009) 10.

113 Ibid., at 13.

Nevertheless, some general conclusions can be drawn. These are mainly based on the introductory part on "The management of De Juana's hunger strike" in Section B of the report. The CPT stated that

> "[i]f a decision is taken to force-feed a prisoner on hunger strike, in the CPT's view, such a decision should be based upon *medical necessity* and should be carried out under *suitable conditions* that reflect the medical nature of the measure. Further, the decision-making process should follow an established procedure, which contains sufficient safeguards, including *independent medical decision-making*. Also, *legal recourse* should be available and all aspects of the implementation of the decision should be adequately *monitored*."

According to the CPT, the decision to force-feed a prisoner or detainee on hunger strike must be founded on the following elements: medical need, appropriate conditions and due safeguard provisions, including independent medical decision-making; to which it is necessary to add the availability of legal recourse and appropriate control of all the aspects appertaining to the implementation of the decision.[114] The CPT furthermore added that

> "*the methods used to execute force-feeding* should not be unnecessarily painful and should be applied with skill and minimum force. More generally, force-feeding should infringe the physical integrity of the hunger striker as little as possible. Any resort to physical constraint should be strictly limited to that which is necessary to ensure the execution of the force-feeding. Such constraint should be handled as a medical matter."

The CPT concluded by stating that if these standards are not met, "the force-feeding could very well amount to inhuman or degrading treatment".[115] After these general remarks on the management of hunger strikes, the CPT addressed the establishment of medical necessity, the suitable conditions, the independent medical decision-making, the legal recourse and monitoring and the methods applied (including the use of restraints) in the case of De Juana.[116] In the report, among other things, the CPT stressed the importance of ongoing psychiatric assessment of a prisoner on hunger strike, a constant dialogue with the hunger striker and those persons whom he wishes to represent him, and close monitory by, or on behalf of, the competent judicial authorities to assure that the force-feeding is executed in a manner which is the least harmful to the physical integrity of the hunger striker and that force-feeding

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114 As also reiterated by the CPT in the Response of the Spanish Government to the report of the CPT on its visit to Spain from 14 to 15 January 2007. Strasbourg, 2 March 2009, p. 9.

115 Visit to Spain from 14 to 15 January 2007, CPT/Inf (2009) 10, at 14.

116 Ibid., at 15ff.

remains a medical necessity.[117] Finally, the CPT concluded that the force-feeding of De Juana met the elements described above. In a response to this report, the Spanish Government, before going into the observations and recommendations of the CPT, noted that

> "As a general consideration, the Spanish Government wishes to state that it agrees with the criteria expressed by the CPT, so as to analyze the management of this case of hunger strike. In particular, the recognition of the duty to which the State is committed so as to guarantee the life of a person under its custody, having recourse to all possible means to avoid the physical decline of the person. Something that might, in this specific case, have become irreversible and have even led to death."[118]

3.5.1. The CPT's and the ECtHR's view on force-feeding prisoners and detainees on hunger strike

How does the view of the CPT on the issue of force-feeding prisoners and detainees relate to the view of the ECtHR as discussed earlier in Ch. 5, § 3.4? It is interesting to compare the views of these two organs, both established by the Council of Europe, but with different mandates and tasks. In comparing the views on force-feeding of the ECtHR and the CPT as discussed above, a few differences can be noted. Generally, the *Nevmerzhitsky* criteria of the ECtHR are quite similar to the *De Juana* criteria. In the *Nevmerzhitsky* case, the ECtHR formulated three criteria to assess whether force-feeding can stand the test of Article 3 ECHR: 1) the medical necessity must have been convincingly shown to exist; 2) the procedural guarantees for the decision to force-feed must be complied with; and 3) the manner in which the applicant is subjected to force-feeding must not transgress the threshold of a minimum severity as envisaged by Article 3 ECHR. These criteria can also be identified in the CPT's visit report on the hunger strike of De Juana. As observed above, the CPT states that a decision to force-feed should be based upon medical necessity and the decision-making process should follow an established procedure, which contains sufficient safeguards. The CPT phrased the third criterion (force-feeding may not go beyond a minimum level of severity) differently: "[t]he methods used to execute the force-feeding should not be unnecessarily painful and should be applied with skill and minimum force, and should infringe the physical integrity of the hunger striker as little as possible".

However much the two views on force-feeding prisoners on hunger strike resemble each other in this regard, the De Juana report shows that the focus of the ECtHR and the CPT differ, as the CPT emphasises the medical aspects and nature

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117 Ibid., at 16, 17, and 27.

118 Response of the Spanish Government to the report of the CPT on its visit to Spain from 14 to 15 January 2007. Strasbourg, 2 March 2009, p. 5.

of force-feeding. First of all, the CPT highlights in its report that force-feeding should be medically necessary. Furthermore, it states that force-feeding should be carried out under suitable conditions that reflect the medical nature of the matter, the national procedures must include independent medical decision-making, and the constraint of the hunger striker should be handled as a medical matter. The CPT's emphasis on the medical aspects and nature of force-feeding can, in my opinion, be explained by both its composition, and the nature of the ECtHR (as well as the EComHR) criteria that make the determination of whether Article 3 has been violated in a specific case dependent on, inter alia, the medical necessity and how the force-feeding (a medical intervention) has been applied. The latter makes the CPT investigation into these medical aspects crucial to determine whether a hunger striker has been ill-treated in a specific case.[119]

The CPT's report on the hunger strike and force-feeding of De Juana is remarkable because it was the first report in which the CPT explored the issue of the treatment of prisoners on hunger strike in general and the issue of force-feeding in particular. This report is also remarkable for its content. Until its visit report on the hunger strike of De Juana, the CPT generally dealt with hunger strikes by referring to the WMA Declarations of Tokyo and Malta. This is the case in, for instance, a visit report on a visit to the Netherlands (Aruba) in 2007, in which the CPT concluded "that clear written instructions should be available in prisons on the steps to be taken in the event of a hunger strike". In a footnote, the CPT observed "[s]ee e.g. the World Medical Association Declaration on Hunger Strikers (Pilanesberg, South Africa, 2006)".[120] In a report on a visit to Latvia in 1999, the CPT "recommends that the Latvian authorities draft a policy document on the treatment of hunger strikers, having regard to the relevant international standards and rules on the subject".[121] Moreover, in the report on the 2000-2001 visit to Turkey, the CPT noted, after observing that the issue of force-feeding hunger strikers was a delicate matter on which different views were held: "[t]he CPT understands that the World Medical Association is currently reviewing its policy on this subject".[122] Apparently, the CPT attached great value to the Declarations of Tokyo and Malta. As I observed in Ch. 5, § 2.2, these Declarations explicitly prohibit medical professionals from force-feeding competent prisoners on hunger strike. Several CPT reports also stress that it is up to the physicians concerned to decide whether force-feeding should be applied. These physicians are bound by the medical ethics codified in the Declarations of Tokyo and Malta, which strongly oppose force-feeding. It is highly remarkable and maybe even a radical change in policy that, in the report on De

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119 For this reason, the visit to De Juana was carried out by a delegation which included a medical doctor.

120 Visit to the Netherlands (Aruba) in 2007, CPT/Inf(2008) 2, at 83.

121 Visit to Latvia in 1999, CPT/Inf (2001) 27, at 78.

122 Visit to Turkey in 2000 (December) and 2001 (May), CPT/Inf (2001) 31, at 33.

Juana's hunger strike, the CPT formulated criteria to assess whether force-feeding constitutes ill-treatment (the term the CPT uses to cover torture and inhuman or degrading treatment or punishment).

But is it really? I believe not. The ECtHR ruled in the *Nevmerzhitsky* case in 2004. The report on De Juana's hunger strike was published in 2009. Prior to that, the CPT had repeatedly stated that it refrained from adopting a stance on the matter. Still, the CPT seemed to be opposed to force-feeding prisoners on hunger strike, as it also repeatedly stressed that the management of hunger strikers should be based on a doctor/patient relationship and consistently referred to the WMA declarations that oppose force-feeding prisoners on hunger strike. In the report on De Juana's hunger strike, the CPT formulated criteria that resemble those phrased by the ECtHR. This is not remarkable, as the Explanatory Report of the ECPT in Article 22 stipulates that "[t]he reference to Article 3 of the European Convention on Human Rights will provide [the CPT] with a point of reference for its consideration of situations liable to give rise to torture or inhuman or degrading treatment or punishment (see *infra*, paragraphs 26 and 27)". Also, in its first General Report, the CPT had declared that it "has the right to avail itself of legal standards contained in not only the [ECHR] but also in a number of other relevant human rights instruments (and the interpretation of them by the human rights organs concerned)". The CPT added that "[a]t the same time, it is not bound by the case-law of judicial or quasi-judicial bodies acting in the same field, but may use it as a point of departure or reference when assessing the treatment of persons deprived of their liberty in individual countries."[123] In particular, this last approach was reflected in De Juana report. The CPT not only used the criteria formulated by the ECtHR as a frame of reference to decide in this individual case, but also seized this opportunity to elaborate on them and to indicate how they should be applied in practice to assess whether force-feeding a prisoner on hunger strike constitutes ill-treatment. Does this imply that the CPT approves of prisoners on hunger strike being force-fed? No, it does not. The CPT concluded its De Juana report by saying that

> "[n]othing in this report should be interpreted to mean that the CPT believes that it is right to force-feed a detained person. On the contrary, this Committee believes that it is not its role to pronounce on this question. Nevertheless, if a decision to force feed an inmate is taken, such a decision should at a minimum meet the criteria [as listed in this report]."[124]

While the CPT (again) noted in this passage that it is not its role to pronounce on this question, it also clearly stated that its report must not be seen as an endorsement of the right to force-feed prisoners on hunger strike.

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123 *1st General Report,* CPT/Inf (91) 3, paragraph 5.

124 Visit to Spain from 14 to 15 January 2007, CPT/Inf (2009) 10, at 34.

It can be concluded that, in the 2004 *Nevmerzhitsky* case, the ECtHR left some room for Member States to apply force-feeding to prisoners on hunger strike as long as certain criteria were met. As stated in Ch. 3, § 2.2.4, the CPT, unlike the ECtHR, is not a judicial mechanism and so the CPT has long refrained from taking a stance on this matter. Also, like the EComHR and ECtHR, it left the decision to whether States intervene in hunger strikes through force-feeding to the degree of interpretation that they enjoy. But if States decide to intervene through the use of force-feeding, in the De Juana report the CPT has given safeguards in order to prevent it constituting ill-treatment. Although, in its report on De Juana, the CPT again stated that it is not its role to pronounce on this question, the report reflected the CPT's reservations on the use of force-feeding prisoners on hunger strike. In the report, the CPT rightfully noted that "the majority of national legislatures in Europe, as well as the relevant international medical codes, today consider that a competent adult may choose to refuse medical treatment even if it could save his life".[125] Nevertheless, several countries in Europe still intervene in hunger strikes through the use of force-feeding to preserve the life of the hunger striker, For instance, in Spain, the Constitution stresses the value of life, which is reflected in Article 3.4 of the Penitentiary Code, which states that the life and health of an inmate should be safeguarded. Furthermore, the Spanish Constitutional Court has decided, in four separate rulings, that prisoners on hunger strike may be force-fed.[126] During its visit to De Juana, the CPT was confronted with the Spanish approach to force-feeding prisoners on hunger strike. In response, the CPT formulated minimum standards for the use of force-feeding to examine whether the force-feeding constituted ill-treatment in this specific case. If these minimum standards are not met, the CPT is likely to consider force-feeding ill-treatment.

It is not inconceivable that the next time the ECtHR is confronted with a case concerning this issue, it will use the CPT criteria to assess whether Article 3 ECHR has been violated, especially considering the mutual influence between the two organs.[127] The formulation of these criteria is an example of the CPT exercising its preventive role in protecting prisoners on hunger strike against ill-treatment. In its report on De Juana, the CPT provides guidelines for the humane treatment of prisoners on hunger strike, having regard to both the medical and the legal aspects. In this way, it offers guidance to all the parties involved in such a complex and delicate matter. The CPT having formulated these minimum standards does not imply that the CPT is in favour of force-feeding prisoners on hunger strike. I believe that the report on De Juana's hunger strike reflects the underlying dilemma with regard to force-feeding prisoners on hunger strike of the legal approach versus the medical-ethical perspective. The CPT's composition embodies this dilemma;

125 Ibid., at 13.

126 Ibid., listed under footnote 3.

127 On this mutual influence and the relation between these two organs: see Hagens 2011.

its members include lawyers as well as medical professionals. The De Juana visit report reflects the view that prisoners on hunger strike should not be force-fed, but at the same time it points out that current practices call for minimum standards for force-feeding.

4. NGO ANALYSIS OF FORCE-FEEDING PRISONERS AND DETAINEES ON HUNGER STRIKE

The UN and the Council of Europe and their organs are not the only ones to have looked at the issue of force-feeding and prisoners and detainees on hunger strike. As it involves an issue of constituting or risking violations of human rights and medical ethics, several NGOs have also dealt with this topic. Below, I will go into the views of four NGOs that have devoted themselves to this topic, i.e., Penal Reform International, Amnesty International, the ICRC and the Dutch Johannes Wier Foundation.

4.1. PENAL REFORM INTERNATIONAL

As stated in Ch. 3, § 2.1.1, Penal Reform International is an international NGO concerned with penal and criminal justice reform worldwide. In the 2001 handbook *Making Standards Work*, it provides an overview of the UN rules on prison conditions and treatment of prisoners for those working with prisoners and those responsible for their care and treatment.[128] The term "prisoner" in this document is understood in the widest sense, covering all persons who are deprived of their liberty. The handbook contains stipulations on, for example, the right to life and integrity of the person and the right to health. Under Section IV (on prisoners' physical and mental health), Paragraphs 53-55 are devoted to the issue of hunger strikes. In Paragraph 53, a distinction is made between a refusal to eat as a protest (a hunger strike), as a symptom of mental disturbance, or as a free choice to end one's life. If a prisoner or detainee refuses to eat as a form of protest, "it is not a medical problem in the first place, but a political or social problem. It is of prime importance to realize this." Paragraph 53 furthermore notes that:

> "Examining a prisoner who is on hunger strike and reporting about his or her condition may lead to forced feeding. It may even lead to ordering the doctor himself to administer liquid food against the will of the prisoner, thus annulling a prisoner's protest and allowing them ignore it. This definitely is unjust. As it is stated in the *World Medical Association's Declaration on Hunger-Strikes. '… It is the duty of the doctor to respect the autonomy which the patient has over*

[128] Penal Reform International 2001.

his person.' The W.M.A.'s Declaration recognizes the doctor's conflict to both respect the patient's autonomy, and act in what is perceived to be the patient's best interest. The Declaration, however, states, that, if a doctor *'agrees to attend to a hunger-striker, that person becomes the doctor's patient'*, with all inherent implications, '*including consent and responsibility.*' Further the Declaration states: *"The ultimate decision on intervention or non-intervention should be left with the individual doctor without the intervention of third parties whose primary interest is not the patient's welfare."*

Penal Reform International subscribes the 1991 WMA Declaration of Malta.[129] By doing so, it opposes force-feeding and emphasises the patient's autonomy. The value attached to the WMA Declarations is also stressed in Article 55, which states that:

"Prison policy should be in accordance with the following principles, formulated in the *Tokyo (1975) and Malta (1992)* [sic. 1991 is meant here] *Declaration* of the *World Medical Association* concerning a refusal to eat:

There is a moral obligation on every human being to respect the sanctity of life. This is especially evident in the case of a doctor who exercises his skills to save life and also acts in the best interests of his patients (beneficence).

It is the duty of the doctor to respect the autonomy which the patient has over his person. A doctor requires informed consent from his patients before applying any of his skills to assist them, unless emergency circumstances have risen in which case the doctor has to act in what is perceived to be the patient's best interests.

Furthermore they declare:

The ultimate decision on intervention or non-intervention should be left with the individual doctor without the intervention of third parties whose primary interest is not the patient's welfare

From the guidelines the following may be mentioned:

- *Doctors or other health care personnel may not apply undue pressure of any sort on the hunger-striker to suspend the strike;*
- *The hunger-striker must be professionally informed by the doctor of the clinical consequences of a hunger strike;*
- *Any treatment administered to the patient must be with his approval;*
- *The doctor should ascertain on a daily basis whether or not the patient wishes to continue with his hunger strike.*

[129] Although in the text below "Malta (1992)" is mentioned, this should be "Malta (1991)".

Accordingly, custodial policy should be in accordance with the WMA Declarations, not only as regards force-feeding, but also where the overall treatment of hunger strikers is concerned.

4.2. AMNESTY INTERNATIONAL

Amnesty International is a worldwide movement of people who campaign for internationally recognised human rights for all. Since 1961, it has worked to improve human rights through campaigning and international solidarity. In their *Combating Torture: A Manual for Action*, Amnesty International notes that "[t]here is no UN standard concerning the forcible feeding of prisoners who are on a hunger strike". It refers to the Tokyo Declaration, which explicitly forbids force-feeding, and the Malta Declaration, which contains a more elaborate set of guidelines for physicians involved in the treatment of hunger strikers. Amnesty International furthermore notes that: "[i]n addition to the standards described above, every prisoner should have a medical file which follows them throughout their time in custody".[130]

Amnesty International has been involved in numerous cases of prisoners and detainees on hunger strike during the past 30 years. James Welsh of Amnesty International has summarised his organisation's involvement in the matter, which started with its work on the conditions of detention of members of the *Rote Armee Fraktion* in Germany in the late 1970s, during which one of the hunger strikers died.[131] Amnesty International's experience of this hunger strike led to prolonged discussion in the International Secretariat whether force-feeding was in all cases cruel, inhuman or degrading and thus contrary to human rights, or whether there might be circumstances where such as procedure could be compatible with the hunger striker's human rights. Some members of Amnesty International's medical network urged a position against force-feeding, in line with the 1975 WMA Declaration of Tokyo, but the emerging consensus, and the subsequent policy, opted to oppose feeding carried out in a cruel manner but otherwise to take no position in favour or against involuntary feeding itself. According to Welsh, the policy noted that "refusal of a prisoner to take food does not constitute any human rights violation", nor did "the refusal of a government to concede to the demands of hunger striking prisoners [necessarily] constitute a human rights violation". The policy called for access to medical care to be assured and for governments to concede to the demands of hunger strikers where they were based on human rights

130 Amnesty International 2003, pp. 124-125.

131 Welsh 2009, p. 148 ff. Current policy in Germany and the development of this policy will be described in the next chapter.

(for example, to end the use of torture). Since the 1990s, this has guided Amnesty International's work in hunger strikes.[132]

When applied to the situation at Guantánamo Bay, Welsh concludes that the methods used to respond to hunger strikes "represent a transparently oppressive response by the state intended to maintain prisoners in a condition of a profound denial of human rights" and they "constitute a form of cruel, inhuman, or degrading treatment intended to break the strike and to form part of the stripping away of prisoners' human rights."[133] In addition, Welsh notes in general that Amnesty International (and other human rights organisations) often face practical difficulties in evaluating reports of hunger strikes from afar, since uncertainty exists about, *inter alia*, the voluntary aspect of the hunger strike, the mental status of the fasting prisoner, the role of health personnel and so forth. For this reason, Amnesty International will often be unable to determine conclusively whether a particular case of force-feeding is consistent with international ethics and human rights standards.[134] Therefore, they are not in a position to properly evaluate the situation of the hunger striker. It can be concluded that Amnesty International, in contrast to, for example, the ICRC (see below), does not so much focus on the legitimacy of force-feeding of hunger strikers, but on the fact that a hunger strike is a form of protest. It addresses the reasons behind the hunger strike, mostly alleged human rights violations such as torture or other abusive practices in prisons or other places of detention. This is in line with Hogan's definition of a hunger strike as "any refusal of all necessary food, intending to continue it, in protest against injustice".[135] Welsh states that

> "Because the outcome of a prolonged hunger strike may be the death of the hunger striker, it is essential that prison administrations and government authorities ensure that any human rights violations that might have provoked the food refusal are addressed. Analysis of the factors prompting the hunger strike may impose additional obligations on the state and bear on the kind of demands made to states to bring their behaviour into conformity."[136]

Accordingly, custodial authorities must address human rights issues of torture and other practices to prevent protest actions such as prolonged hunger strikes.

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132 Ibid., p. 150.

133 Ibid., p. 169.

134 Ibid., p. 171.

135 Hogan 1933, p. 14. See Ch. 1, § 2.5.4.

136 Welsh 2009, p. 171.

4.3. THE ICRC

The ICRC was founded in 1863, and initially focused on the protection of and assistance to wounded soldiers in armed conflict and other situations of violence, but over time extended its activities to cover all victims of these events. According to the ICRC, it is

> "an impartial, neutral and independent organization whose exclusively humanitarian mission is to protect the lives and dignity of victims of armed conflict and other situations of violence and to provide them with assistance. The ICRC also endeavours to prevent suffering by promoting and strengthening humanitarian law and universal humanitarian principles."[137]

The ICRC endorses the WMA Declarations of Tokyo and Malta and is opposed to force-feeding hunger strikers. On a visit to detainees in Israel on hunger strike, it noted: "[d]uring the visits, the doctors will stress the possible health consequences of the strike and urge the authorities not to subject detainees to force-feeding or any other form of duress".[138] On many occasions, Dr Hernán Reyes of the ICRC has made a stand against physicians being party to force-feeding. In a 1998 article on this issue, he stated that:

> "Doctors should never be party to actual coercive feeding, with prisoners being tied down and intravenous drips or oesophageal tubes being forced into them. Such actions can be considered a form of torture, and under no circumstances should doctors participate in them, on the pretext of saving the hunger striker's life. Heeding the informed consent of a hunger striker, confirmed within the trust of the doctor-patient relationship, and respecting the intrinsic dignity of the fasting prisoner he is treating is certainly part of the doctor's duty in looking after the patient's welfare."[139]

4.4. THE JOHANNES WIER FOUNDATION

The Johannes Wier Foundation is a Dutch human rights organisation for health professionals. The focus of the organisation is on the specific responsibility of all

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137 <http://www.icrc.org/web/eng/siteeng0.nsf/html/icrc-mission-190608> (last accessed on 17 January 2012).

138 ICRC News Release dated 27 August 2004, "Israel: Visits to detainees on hunger strike", <http://www.icrc.org/Web/Eng/siteeng0.nsf/iwpList74/75579B6BB769D3B5C1256EFD0047576F> (last accessed on 17 January 2012).

139 Reyes 1998. See also Reyes 2007.

health care workers regarding human rights.[140] This foundation has developed a manual with detailed guidelines for physicians and other health personnel dealing with hunger strikers.[141] In this manual, a response consistent with WMA standards is advocated. It underlines that competent hunger strikers (both in freedom and in custody) may not be force-fed, and that physicians and other health personnel should never be involved in such practices. Furthermore, it states that every hunger striker has the right to medical guidance by a trusted doctor (*vertrouwensarts*), who is not affiliated with the prison or other place of detention to facilitate a relationship of trust with the hunger striker.[142] The view of the Johannes Wier Foundation on force-feeding is in line with the view of the Royal Dutch Medical Association (*Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst*, the professional organisation for physicians in the Netherlands, established in 1849).[143] The guidelines of the Johannes Wier Foundation were translated into several languages and are widely used as a source of guidance in dealing with hunger strikers.

5. CONCLUSIONS

In this chapter, I addressed international and European documents on force-feeding prisoners and detainees on hunger strike. I also discussed the legitimacy of force-feeding by several human rights mechanisms in individual cases. On an international level, UN human rights agreements, such as the Principles of Medical Ethics and the SMR, do not contain provisions for the use of force-feeding, but only assess issues that indirectly relate to force-feeding, such as the use of force against prisoners and detainees in general and the use of restraints. UN agreements that formulate human rights for prisoners and detainees, as well as more general human rights documents such as the Convention against Torture (especially Articles 10 and 11) and the Geneva Conventions (especially common Article 3) focus on the importance of protecting the rights and integrity of persons in custody. However, because of their very general wording, they have not strongly influenced the debate on force-feeding. No human rights agreements exist which directly address the issue of force-feeding prisoners and detainees on hunger strike. Apparently, it is difficult to draw general guidelines on this human rights issue on which, globally and nationally, very different opinions are held.

Yet several human rights mechanisms have voiced an opinion on the legitimacy of force-feeding prisoners and detainees on hunger strike when confronted with

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140 <http://www.johannes-wier.nl>.

141 Van Es, Van Ojen & Raat 2000. Translation in English: Johannes Wier Foundation 1995.

142 This trusted doctor will be selected through the "Network of trusted doctors" (*Netwerk Vertrouwensartsen*) administered by the Johannes Wier Foundation.

143 See Ch. 6, § 2.8.

individual cases. In 2006, the Special Rapporteurs on torture and the right to health voiced a strong opinion on this matter, in the report on the situation of prisoners at US Naval Base Guantánamo Bay, a case in which a need was apparently felt to clarify that the force-feeding practices here were unacceptable. The Special Rapporteur on torture in this report concluded that the excessive violence used at the Naval Base must be assessed as amounting to torture as defined in Article 1 of the Convention against Torture. The Special Rapporteur on the right to health concluded more generally that competent prisoners and detainees may not be force-fed. This statement is unique, as it is phrased in unambiguous terms, and because it univocally states that force-feeding competent prisoners not only violates the ethical duties of any health professionals who may be involved, but it also violates the right to health of the hunger striker involved. Also in 2006, a very different approach was voiced by the Trial Chamber of the ICTY, confronted by a prolonged hunger strike by alleged Serbian war criminal Šešelj. The Trial Chamber was prepared to force-feed this competent hunger striker to prevent him from dying and not being able to stand trial. It issued a force-feeding order to the Dutch authorities

> "to provide medical services under the Agreement – which may, in the case of medical necessity, include intervention such as drip-feeding – with the aim of protecting the health and welfare of the Accused and avoiding loss of life, to the extent that such services are not contrary to compelling internationally accepted standards of medical ethics or binding rules of international law."[144]

Although this order shows awareness of the fact that medical ethics may contravene such an approach, the Trial Chamber determined that in this case the administration of justice prevailed over the hunger striker's individual rights. It remains unclear, however, how the Trial Chamber would reconcile the application of force-feeding with internationally accepted standards of medical ethics.

On a European level, a more or less similar approach towards the issue of force-feeding can be found. Although European agreements contain stipulations that indirectly concern the issue of force-feeding (such as the issue of prisoners' and detainees' informed consent, and, again, the use of force against prisoners and detainees in general and the use of restraints), policy on this issue has been mostly shaped by assessment of individual cases by the Council of Europe's supervisory human rights mechanisms such as the EComHR, the ECtHR, and the CPT. Although the judgment in individual cases, as their facts may strongly differ, may lead to very different final judgments on the legitimacy of force-feeding, as shown by the different opinions on force-feeding illustrated in the UN report on Guantánamo Bay, and the force-feeding order by the ICTY's Trial Chamber, the number of cases dealt

144 Ibid., p. 6.

with by the EComHR, ECtHR and CPT have provided them with an opportunity to develop a finely meshed assessment framework for this issue.

As early as 1984, the EComHR stated that "forced-feeding does involve degrading elements which in certain circumstances may be regarded as prohibited by Article 3 of the Convention" and that hunger strikes "may inevitably lead to a conflict between an individual's right to physical integrity and the High Contracting Party's positive obligation under Article 2 of the Convention – a conflict which is not solved by the Convention itself". Since 1984, the ECtHR has considered the legitimacy of force-feeding of hunger strikers and the relationship between Articles 2 and 3 in several cases, eight of which were described in this chapter.

In these cases, the EComHR and ECtHR have gradually developed their policy on hunger strikers, culminating in the 2005 landmark case of *Nevmerzhitsky*. In the case of *Nevmerzhitsky*, the ECtHR has determined that a measure which is of therapeutic necessity from the point of view of established principles of medicine, such as force-feeding, cannot in principle be regarded as inhuman and degrading, if 1) the medical necessity has been convincingly shown to exist, 2) the procedural guarantees for the decision to force-feed have been complied with, and 3) the manner in which the applicant is subjected to force-feeding did not transgress the threshold of a minimum severity. If these three criteria are met, force-feeding in principle does not violate Article 3 ECHR, in the view of the ECtHR. It can be concluded that the ECtHR currently is not principally opposed to the force-feeding of prisoners on hunger strike. The ECtHR leaves it to States and their authorities to deal with this matter and to decide for themselves whether they force-feed prisoners and detainees on hunger strike, but if they do decide to apply force-feeding, the *Nevmerzhitsky* criteria have to be met. They may also decide to respect the hunger striker's wishes; the ECtHR has determined that States do not violate their obligations on the basis of Article 2 ECHR if they do not intervene in the hunger strike to save the life of the hunger striker. It can be concluded that in this way the ECtHR stresses that it leaves a wide degree of interpretation for States to decide for themselves how to deal with this matter.

Although the EComHR and ECtHR in their cases provide some guidance for States to determine whether or not they may decide to apply force-feeding or not, the CPT has elaborated on the ECtHR criteria in the report on Spanish hunger striker De Juana. In its visit to Spain, the CPT has addressed the management of his hunger strike in general and the legitimacy of the use of force-feeding in particular. In this report, the CPT elaborates on how the *Nevmerzhitsky* criteria should be applied in practice to assess whether force-feeding a prisoner on hunger strike constitutes a violation of Article 3 ECHR.

In the visit report on De Juana, the CPT stated that a decision to force-feed a prisoner on hunger strike

> "should be based upon medical necessity and should be carried out under suitable conditions that reflect the medical nature of the measure. Further, the decision-

> making process should follow an established procedure, which contains sufficient safeguards, including independent medical decision-making. Also, legal recourse should be available and all aspects of the implementation of the decision should be adequately monitored.

Moreover,

> "the methods used to execute force-feeding should not be unnecessarily painful and should be applied with skill and minimum force. More generally, force-feeding should infringe the physical integrity of the hunger striker as little as possible. Any resort to physical constraint should be strictly limited to that which is necessary to ensure the execution of the force-feeding. Such constraint should be handled as a medical matter."

If these standards are not met, the force-feeding could very well amount to inhuman or degrading treatment, according to the CPT. The criteria formulated by the CPT strongly resemble those developed by the ECtHR in the case of *Nevmerzhitsky*, but place even greater emphasis on the medical aspects of a hunger strike.

In my view, the fact that the CPT has formulated these minimum standards does not imply that the CPT agrees with force-feeding prisoner on hunger strike, but it only acknowledges that current practices call for minimum standards on force-feeding. I also believe that the report on De Juana's hunger strike reflects the underlying dilemma with regard to force-feeding prisoners on hunger strike of the legal approach versus the medical-ethical perspective.

The legal approach by the EComHR and ECtHR on force-feeding is diametrically opposed to the view illustrated in medical ethics. The physician is an indispensable link to the application of force-feeding; without the physician, no force-feeding can take place. The physician takes the final decision on whether to apply force-feeding or not. In my view, the difference in the assessment of legitimacy of force-feeding by lawyers and physicians stems from their different perspectives: lawyers seek to create general rules, which can then be applied to individual cases, while a physician's first concern is the patient, the individual. The physician's perspective is from the bottom up, instead of the lawyer's top-down perspective. In prolonged hunger strikes, physicians are confronted with the conflict between, on the one hand, the need to preserve life and, on the other hand, respect for the autonomy of the individual.

The WMA is strongly devoted to providing guidance to physicians involved in the treatment of hunger strikers. The 1975 Declaration of Tokyo contained a stipulation on hunger strike, but the 1991 Declaration of Malta, with its revisions in 1992 and 2006, is entirely devoted to the issue of hunger strikes, and greatly devoted to force-feeding. Although the Declaration of Malta goes into the issue more extensively, the view of the WMA in the two documents is identical: force-feeding of prisoners and detainees is never ethically acceptable. The Declaration of Malta explicitly states that force-feeding can never be justified and constitutes a form of

inhuman and degrading treatment. Although, as already stated, the Declarations of Tokyo and Malta are merely guidelines and are not binding on States, they are universally considered authoritative for the treatment of prisoners and detainees on hunger strike. Most national medical associations have endorsed the WMA and its declarations. In this way, the Declarations of Tokyo and Malta and Malta form an important medical-ethical guideline for physicians who are involved in the management of hunger strikes. Still, there is no international organisation or mechanism to enforce these medical-ethical guidelines. It remains up to physicians to decide whether they are willing and prepared to apply force-feeding in a specific case. That physicians may also be prepared to deviate from these medical-ethical guidelines, even though their national medical association has committed itself to the WMA is, *inter alia*, demonstrated by physicians' complicity in force-feeding practices at, for example, US Naval Base Guantánamo Bay.

It can be concluded that the European legal framework on hunger strikes is outlined by the EComHR and ECtHR in the case of *Nevmerzhitsky*. However, this case focused strongly on the specific facts of the case (where for example excessive force was used in the application of the force-feeding), and it leaves a number of questions open. Questions that remain unanswered by the EComHR and ECtHR, for example, include the question of what would happen if a prisoner or detainee has drawn up an advance directive when he was still competent? Would force-feeding then still be allowed? And how would force-feeding applied in a more humane way relate to the prisoners' and detainees' right to physical integrity as laid down in Article 8 ECHR? And can third parties' interests justify such intervention? I will go into these questions in Chapter 7. Moreover, the EComHR and ECtHR have left much room for the Member States to decide on the principal question of the legitimacy of force-feeding. These Member States are confronted with physicians who are bound by their medical ethics, which oppose to the use of force-feeding in competent hunger strikers. How do these positions relate to each other? And how do national policies address the principal question of the legitimacy of force-feeding, and the medical-ethical issues involved? To answer this question for three jurisdictions, I will investigate the national policies on force-feeding in the Netherlands, Germany, and England and Wales in the next chapter.

CHAPTER SIX

FORCE-FEEDING OF PRISONERS AND DETAINEES ON HUNGER STRIKE: CURRENT POLICIES AND THEIR DEVELOPMENT IN THE NETHERLANDS, GERMANY, AND ENGLAND AND WALES

1. INTRODUCTION

In the previous chapter I investigated international and European documents and case law on force-feeding prisoners and detainees on hunger strike. As demonstrated there, the ECtHR (and earlier, also the EComHR) is not in principle opposed to the force-feeding of prisoners on hunger strike: if the three criteria as developed in *Nevmerzhitsky* are met, force-feeding in principle does not violate Article 3 ECHR. In the case of *Horoz*, the ECtHR has furthermore ruled that Article 2 ECHR does not constitute an active obligation for States and State authorities to intervene in the hunger strike to preserve the health and life of the hunger striker. From this, it can be concluded that Council of Europe's Member States may choose to force-feed a prisoner or detainee on hunger strike to preserve the life of a prisoner or detainee (as long as the *Nevmerzhitsky* criteria are met), but they are not obliged to do so on the basis of Article 2 ECHR. As concluded in the previous chapter, in this way the ECtHR leaves a wide margin for Member States to deal with this matter on a national level. Worldwide, but also within Council of Europe Member States, opinions differ strongly on the question of whether force-feeding of hunger strikers can be legitimate, and if so, in what cases and under which circumstances.

In this chapter I will elaborate on the opinions of three Council of Europe jurisdictions on force-feeding of prisoners and detainees on hunger strike: the Netherlands, Germany, and England and Wales. In these jurisdictions the matter of force-feeding prisoners on hunger strike is still, or has long been the subject of discussion and debate. They each have a very specific view on the use of force-feeding. Germany, on the one hand, typifies a country that follows the dogmatic approach,

emphasising the interest of the State. England and Wales and the Netherlands, on the other hand, follow the more liberal approach, focusing on the individual's right to self-determination. Obviously, opinions on force-feeding are strongly influenced by the religious, political and social context of a country. Moreover, experiences with hunger strikers in the past have often strongly induced the creation or alteration of policies on the use of force-feeding in hunger strikers. For this reason, not only the current viewpoint, as shown by national legislation, but also the development of this viewpoint and the influence of particular cases on the policy towards the treatment of prisoners on hunger strike will be taken into account. Furthermore, I will investigate the views of the national medical organisations on the issue on force-feeding hunger strikers and whether these medical associations have committed themselves to the declarations of the WMA. Also, I will also investigate possibilities for legal remedy before force-feeding takes place.[1] In this chapter, I will investigate first the Netherlands, secondly Germany, and finally England and Wales. Finally, I will compare these national policies and the development of these policies in the respective jurisdictions, and offer conclusions. All translations in this chapter are by author, unless indicated otherwise.

The main focus is on the possibility of applying force-feeding to *prisoners*, since most national policies on force-feeding have been developed for the specific group of prisoners and hunger strikes by prisoners have strongly shaped current policies (especially in Germany and England and Wales). I will not go into the issue of detainees on hunger strike separately, but will only mention when different considerations apply for this other group of persons who are deprived of their liberty.

2. THE NETHERLANDS

2.1. INTRODUCTION

The Netherlands does not have a turbulent history with hunger strikers, as is the case with Germany and England and Wales. Throughout the years, Dutch policy has consistently placed great value on the prisoners' and detainees' decision to go on hunger strike, and has strongly rejected force-feeding in hunger strikes. Still, the case of Volkert van der G. showed that a high profile hunger strike can severely challenge this policy.

Below, I will go into the Dutch legal framework for the assessment of force-feeding, with special attention for Article 32 of the Penitentiary Principles Act (*Penitentiaire beginselenwet*, hereafter: PPA). Also, I will elaborate on the position of the prison physician, and the applicability of Article 32 PPA to force-feeding prisoners on

[1] I will not go into the possibilities of judicial review or (disciplinary) procedures against, *inter alia*, the physicians who participated in the force-feeding practices after it has occurred.

hunger strike. Furthermore, I will go into the 1985 circular of the State Secretary of Justice on hunger strikes in prison, the issue of advance directives, and deal with two cases in which the question of force-feeding prisoners on hunger strike became topical in the Netherlands: the 2002 case of Volkert van der G., and the 2006 ICTY case of *Šešelj*. Finally, I will offer conclusions on the Dutch policy on force-feeding prisoners on hunger strike.

2.2. LEGAL FRAMEWORK

Within the traditional categories of comparative law, the Netherlands belongs to the circle of civil law countries, like Germany. According to Articles 93 and 94 of the Dutch Constitution (*Grondwet*) "[p]rovisions of treaties and of resolutions by international institutions which may be binding on all persons by virtue of their contents shall become binding after they have been published", and "[s]tatutory regulations in force within the Kingdom shall not be applicable if such application is in conflict with provisions of treaties that are binding on all persons or of resolutions by international institutions".[2] In this way, self-executing provisions of, *inter alia*, the ECHR may be invoked before domestic courts and may set aside conflicting statutory law, including provisions in the Constitution.[3] Below, I will first investigate the legal framework relevant for the assessment of force-feeding prisoners on hunger strike given by the Dutch Constitution, and the more specific laws that govern the position of prisoners.

The right to self-determination is codified in Articles 10 and 11 of the Dutch Constitution. Article 10 states that "[e]veryone shall have the right to respect for his privacy, without prejudice to restrictions laid down by or pursuant to Act of Parliament". Article 11 contains the right to personal integrity and reads as follows: "[e]veryone shall have the right to inviolability of his person, without prejudice to restrictions laid down by or pursuant to Act of Parliament". Articles 10 and 11 of the Dutch Constitution underlie the right to self-determination and are mostly quoted to argue against forced medical treatment.

The principle that competent patients have to consent before medical treatment can be performed was incorporated in the law by the 1995 Medical Treatment Contracts Act (*Wet geneeskundige behandelingsovereenkomst*). The medical treatment agreement (*geneeskundige behandelingsovereenkomst*) governs the relationship between patients and care providers and is codified in Part 5 of Title 7 of Book 7

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2 The English, French, Spanish and German translation of the Dutch Constitution can be retrieved through <http://english.minbzk.nl/subjects/constitution-and/@4800/the_constitution_of> (last accessed on 3 February 2012). All translations from the Dutch Constitution as used in this research derive from the English translation of the document as found on this website.

3 Van Dijk et al. 2006, p. 27.

of the Dutch Civil Code (*Burgerlijk Wetboek*). This medical treatment agreement is not only applicable to patients who are at liberty, but applies *mutatis mutandis* to prisoners.

Article 7:450 of the Civil Code stipulates

1. The consent of the patient is required for any treatment in the performance of a contract of treatment.
2. Where the patient is not of full age and has reached the age of twelve, but not yet that of sixteen year, the consent of the parents exercising parental authority over him or of the guardian is also required. The treatment, however, can also be performed without the consent of the parents of the guardian, if it is clearly necessary to prevent serious harm to the patient, as well as if the patient, even after the refusal of consent, on due consideration still desires the treatment.
3. In the event that a patient of sixteen years or older cannot be considered capable of a reasonable appreciation of his interests in the matter, the clear beliefs of the patient, enunciated in written form when he was still capable of such reasonable appreciation and containing a refusal to consent as referred to in paragraph 1, shall be followed by the provider of care and a person referred to in paragraphs 2 and 3 of Article 465. The provider of care may derogate herefrom, if he considers that there are sound reasons to do so.[4]

Accordingly, patients must consent before medical treatment can be performed. An exception to this rule is created in Article 7:466 of the Civil Code, which stipulates that in cases of minimal invasive treatment, consent is presumed to exist, and in cases of emergency, consent may also be presumed to exist when the time to seek consent is lacking. Article 7:465 of the Civil Code furthermore determines that medical treatment may be performed on incompetent patients, when a guardian, a mentor, a parent with custody, an authorised representative or those closest to the consent to it. If the patient resists, however, this medical treatment can only be performed when necessary to prevent severe damage to the person involved. For the purpose of consent, the patient should always be adequately informed.

Another possibility for forced medical treatment exists under the Psychiatric Hospitals (Compulsory Admissions) Act (*Wet bijzondere opnemingen in psychiatrische ziekenhuizen, Wet BOPZ*). The Psychiatric Hospitals Act gives criteria and procedures for the compulsory admission in a psychiatric hospital. Besides this, the Act stipulates the rights of patients once they have been compulsorily admitted. On the basis of the Psychiatric Hospitals Act, a compulsory admission is only possible if a person suffers from a mental disorder (that has been diagnosed

[4] Translation by Warendorf, Thomas & Curry-Sumner 2009.

by a psychiatrist) and there is (potential) danger to the patient's own safety or the safety of others and/or the goods of others. Article 1, under f), of the Psychiatric Hospitals Act determines what constitutes (potential) danger in the sense of this law. According to this Article, (potential) danger is constituted by the danger that the patient will try to take his own life or seriously injure himself, the danger that he will lose touch with society completely, the danger that he will seriously neglect himself, the danger that others will become aggressive in response to his problem behaviour, the danger that he will threaten to take someone's life or cause serious injury or jeopardise someone else's mental health, or the danger that the patient will neglect someone who has been entrusted to his care, and that he could present a danger to the safety of other people or their property. In all these cases, there has to be a causal relationship between the mental disorder and the danger.

A compulsory admission on the basis of the Psychiatric Hospitals Act does not automatically justify forced medical treatment. Compulsorily admitted patients still have the right to consent before medical treatment may be performed. Necessary forced medical interventions must be laid down in the treatment plan (*behandelingsplan*), which is aimed to diminish the danger arising from the patient's mental disorder that justified the compulsory admission in the psychiatric hospital. If the patient is incompetent, the physicians or psychiatrists involved should consult with the representatives of the patient, or, if no representative is appointed, with the person who on paper is authorised to decide. The treatment plan only comes into effect when the patient agrees to this. Still, the right to refuse treatment is not absolute. Forced medical treatment can be performed if treatment is absolutely necessary to avert the danger caused by the patient's mental disorder. In such a case, the most effective and least drastic method of treatment must be applied. Besides the possibilities for forced medical treatment as laid down in the treatment plan, the Psychiatric Hospitals Act provides possibilities to intervene in temporary emergency situations, the so-called means and measures (*middelen en maatregelen*), mainly used to maintain order in the psychiatric hospital. In such emergency situations, there is often no written treatment plan available, or the treatment plan does not contain stipulations for such eventualities. The legislator has determined which means and measures are allowed: separation, isolation, fixation, medication and the application of food and fluids. These means and measures must be applied proportionately (in relation to the danger involved) and the least invasive method must be chosen. Besides this, these emergency measures may never be used for more than seven days. In these seven days, the treatment plan has to be adjusted. The means or measure must be immediately ended when the danger has passed.

It can be concluded that forced medical treatment is possible with persons who are compulsorily admitted to a psychiatric hospital, but only when laid down in the treatment plan, or when necessary to avert immediate risk. Besides this, a patient must already be compulsorily admitted to a psychiatric hospital, which is only possible if a person suffers from a mental disorder (that has been diagnosed

by a psychiatrist) and there is (potential) danger to the patient's own safety or the safety of others.

At the time of writing (February 2012), new legislation is being prepared to replace the Psychiatric Hospitals Act. Two drafts have been created to replace the Act: the bill on Compulsory Mental Health Treatment (*wetsvoorstel verplichte geestelijke gezondheidszorg*)[5] and the bill on Care and Coercion (*wetsvoorstel zorg en dwang psychogeriatische en verstandelijk gehandicapte cliënten*),[6] the latter specifically designed for the mentally handicapped and mentally disturbed. These legislative proposals are pending in the Lower House.

Compulsory admission in a psychiatric hospital on the basis of the Psychiatric Hospitals Act is possible for food refusers who suffer from a mental disorder, but is not likely to be applied to hunger strikes. Before the entry into force of the PPA in 1999, no legal basis for forced medical treatment in prisoners existed. Before this moment, a link was sought with the stipulations concerning forced medical treatment as laid down in the Psychiatric Hospitals Act to determine whether forced medical treatment was possible in a particular case. Nowadays, forced medical treatment in prisoners is assessed by Article 32 PPA (as elaborated on in the next section).

Article 15, fourth paragraph, of the Dutch Constitution determines that "[a] person who has been lawfully deprived of his liberty may be restricted in the exercise of fundamental rights in so far as the exercise of such rights is not compatible with the deprivation of liberty". As shown above, Article 11 of the Dutch Constitution contains the right to physical integrity, but also determines that this right can be limited by formal law. Restrictions on the constitutional right to physical integrity for prisoners, according to Article 27 PPA can be imposed on the basis of the provisions contained in Chapter VI (Articles 27-35) of the same Act. According to Article 1, under e), the term "*gedetineerde*" as used in the PPA means "a person serving a custodial sentence or detention order". A custodial sentence is defined in Article 1, under s), as a sentence of imprisonment, (alternative) detention, military detention, and (alternative) juvenile detention. A detention order is defined in Article 1, under t), as pre-trial detention, custody of aliens, imprisonment for debt, detention under a hospital order and deprivation of liberty on other grounds than those as mentioned in Article 1, under s), of the PPA. Although this group is wider than the group of prisoners as defined in my research, some who are deprived of their liberty do not fall under the PPA, such as those compulsorily admitted under the Psychiatric Hospitals Act, juveniles, suspects in a police cell, aliens who are detained for the purpose of expulsion (except those who are detained in a penal institution) and forensic patients who are detained under a hospital order (*terbeschikkingstelling*), except those who are detained in a penal institution. For these groups, special rules

5 *Kamerstukken II* 2009-2010, 32 399, No. 2.

6 *Kamerstukken II* 2008-2009, 31 996, No. 2.

and regulations have been developed. In the following, I will use the term prisoner to refer to the term "*gedetineerde*" as used in the PPA.

2.3. ARTICLE 32 PPA

A legal basis for the application of a medical intervention without a prisoner's consent can be found in Article 32 PPA. This Article plays a crucial role in assessing the legitimacy of force-feeding prisoners and detainees in Dutch law. The first paragraph of Article 32 reads as follows

> "The governor may oblige a prisoner to acquiesce having a specific medical intervention carried out on him if in the opinion of a physician this intervention is necessary to avert serious risk to the health or safety of the prisoner or of others. The intervention shall be performed by a physician or, on his instructions, by a nurse."[7]

On the basis of Article 32 PPA the prison governor may decide that a prisoner has to accept that medical treatment on him is performed without his consent. According to the Explanatory Memorandum with this Article, the Minister of Justice and the prison governor have joint responsibility for the prisoner whilst he is deprived of his liberty. This responsibility can lead to the application of medical treatment on the basis of Article 32 when the health or safety of the prisoner is threatened. With a serious risk to health or safety of others, in the literature "others" is understood as referring to a serious risk to health or safety other prisoners or prison staff.[8] A serious risk to the health or safety consists, according to the Explanatory Memorandum, of a serious threat to the prisoner's life or a risk of severe self-mutilation or permanent disability. This stipulation was created with regard to the increasing number of prisoners with severe mental disorders, who manifest uncontrolled, and without medical intervention uncontrollable, behaviour. In such cases, Article 32 confers authority on the prison governor to decide that a prisoner has to accept that medical treatment is performed. Still, Article 32 does not create an *obligation* on the medical professional to act. If intervention is to be performed, and if so what that intervention is, is left to the physician's judgment. He will decide on the basis of his professional standards. Nevertheless, Article 32 PPA explicitly legitimises the physician to act against the patient's express wishes and, in this way, to infringe

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7 In Article 32 of the PPA, the words "*geneeskundige handeling*" are used. This is translated as "medical intervention". This terminology is in my opinion used to indicate that the medical intervention is intended as a short-term emergency measure. In this way, it must be distinguished from a "*geneeskundige* be*handeling*" (medical treatment), which is specifically intended to treat and to heal the patient and to have a long-term therapeutic effect on him. Still, in this research the terms medical intervention and medical treatment are used interchangeably (see Ch. 1, § 2.4).

8 Moerings & Zandbergen 2001, p. 113.

on his physical integrity.[9] The Hospital Orders Act (*Beginselenwet verpleging ter beschikking gestelden*) and Youth Custodial Institutions Act (*Beginselenwet justitiële jeugdinrichtingen*) in Articles 21 ff and 32 ff respectively contain similar stipulations as Article 32 PPA for both persons held under a hospital order and juveniles in custody.

Article 32 PPA is specified in greater detail in Chapter 5 (Articles 21-23) of the Penitentiary Order (*Penitentiaire maatregel*). Article 21 of the Penitentiary Order determines that before the governor decides that the medical intervention deemed necessary by the physician must be carried out under duress, he must consult this physician and the head of the wing where the prisoner is staying. If another physician carries out the intervention, this physician must also be consulted. The second paragraph of Article 21 of the Penitentiary Order adds that if the medical intervention must be carried out under duress in order to avert serious risk arising from the prisoner's mental disorder, a psychiatrist must also be consulted. The third paragraph contains the need for proportionality and subsidiarity in the application of such treatment: it must always be considered whether the severe risk cannot be averted in other, less invasive ways, and the medical intervention that poses the least risk to the prisoner must always be chosen. On the basis of the fourth paragraph of Article 21 of the Penitentiary Order, the responsible physician must ensure that giving notice of the application of Article 32 PPA, the results of the consultation, as well as the arrangements made, are registered in the prisoner's medical file. Furthermore, the treatment must be carried out in a room suited for that specific purpose under the responsibility of the physician, and the Minister of Justice and the prison's supervisory committee must be notified immediately of the forced medical treatment. If the medical intervention is carried out to avert serious risk arising from the prisoner's mental disorder, the competent regional public health inspector must also be notified. Also, the prisoner shall be visited as often as necessary by a physician or, on his instructions, by a nurse during the period following the forced medical intervention. The report of his findings shall be included in the medical file (Article 22 of the Penitentiary Order).

It can be concluded that Article 32 or the PPA provides possibilities to forcibly apply medical treatment to avert serious risks to the prisoners own or others' health or safety. In practice, this Article is frequently applied. In the Forensic Observation and Guidance Unit (*Forensische Observatie en Begeleidings Afdeling*)[10] forced medical treatment on the basis of Article 32 is applied in about hundred cases annually, mostly in psychotic prisoners.[11] Case law from the Council for the Administration

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9 *Kamerstukken II* 1994/95, 24 263, No. 3, pp. 52-53.

10 Forensic Observation and Guidance Unit, division of "Het Veer"; a part of penal institution Amsterdam Over-Amstel.

11 *Dwangbehandeling binnen de tenuitvoerlegging van straffen en maatregelen.* Advies Raad voor Strafrechtstoepassing en Jeugdbeleid, 4 February 2008.

of Criminal Justice and Youth Protection also shows that Article 32 PPA is almost solely used in mentally disturbed persons.[12]

At the time of writing, new legislation is being prepared to amend the PPA, the Hospital Orders Act and Youth Custodial Institutions Act to extend the possibilities for forced medical treatment under these acts. This legislative proposal is pending in the Lower House. Still, this new legislation does not intend to change the existing policy and legislation relating to persons on hunger strike.[13]

2.4. THE PRISON PHYSICIAN

According to Article 42 PPA, a prisoner has the right to medical care by a physician provided by the prison, or his substitute. As a rule, prisons have a general practitioner, a dentist and a psychiatrist at their disposal. General practitioners working in prisons are mostly physicians who have a medical practice outside the prison. Although the physician working in the prison is the first care provider for prisoners, the prisoner has the right to a consultation with a physician of his own choice, at his own expense (Article 42, second paragraph). In this way, the prisoner is given the possibility to turn to another physician than the one that is provided by the prison. If the prison physician refuses to cooperate in the performance of a certain medical treatment, a forensic physician or a physician of the Municipal Health Service (GGD) can be contacted.[14] This physician can then be considered a physician in the sense of Article 42 PPA.

A prison physician cannot be forced to execute certain medical treatments, such as ordered by the prison governor, if he refuses to execute such treatment. Although the prison governor may oblige a prisoner to acquiesce to having a specific medical intervention carried out on him, the governor cannot infringe on the professional autonomy of the physician, who is bound by his own professional medical standards. The State and its authorities cannot intrude upon the physician's autonomous decision-making. The same goes for the application of medical treatment on the basis of Article 32 PPA. The Explanatory Memorandum with Article 32 PPA states explicitly that this Article confers authority on the prison governor to decide that a prisoner has to accept that medical treatment is performed, but it does not create an *obligation* for the medical professional to act. The obligation of Article 32 PPA to acquiesce to having a specific medical intervention is directed at the prisoner, not to the physician. It can be concluded that the prison governor

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12 See, *inter alia,* Beroepscommissie RSJ d.d. 29 oktober 2009, No. 09/1852/GA, Beroepscommissie RSJ d.d. 20 mei 2010, No. 10/0519/GA and Beroepscommissie RSJ d.d. 16 mei 2010, No. 10/2885/GA. The last two cases involved the treatment of psychotic prisoners.

13 *Kamerstukken II* 2010-2011, 32 337, No. 6, p. 8.

14 On the physician's dual loyalties, see Ch. 3, § 3.

may oblige a prisoner to undergo medical intervention against his wishes, but he cannot force a physician to execute a certain medical treatment. The physician has his own responsibility for his decisions, and can be held responsible for this by the Healthcare Inspectorate of the Public Health Supervisory Service (*Inspectie voor de Gezondheidszorg*).

2.5. ARTICLE 32 PPA AND FORCE-FEEDING PRISONERS AND DETAINEES ON HUNGER STRIKE

As stated above, Article 32 PPA provides possibility for medical intervention against the prisoner's wishes. If this Article were to be applicable to the forcible administration of food and/or fluids, this would offer an opening for the application of force-feeding to prisoners and detainees on hunger strike, providing a legal basis for the prison governor to decide a prisoner must be force-fed. Can the application of food and/or fluids be considered a "medical intervention" in the sense of Article 32 PPA? The legislator has answered this question in a positive sense. In the legislative history it is stated that "In certain cases, artificial feeding can be considered a medical treatment that the prison governor can oblige the prisoner to accept".[15] Still, the legislative history also shows that the legislator has given consideration to the specific situation of force-feeding prisoners on hunger strike. In response to questions on this topic, the legislator has stated that in cases of hunger or thirst strike the prisoner's own free will is chosen as the basic assumption. Because the prisoner's own free will is here referred to as a "basic assumption", this seems to suggest that there is room to deviate from this basic assumption, and to allow force-feeding. Still, after formulating the basic assumption with regard to hunger strikes, the legislator refers in the legislative history of Article 32 PPA to the WMA Declaration of Tokyo, which underlines the basic principle that, if a prisoner refuses food and is assessed as capable of forming an unimpaired judgment of the possible consequences (i.e. is competent), he must not be force-fed. Here, the legislator emphasises that the hunger striker's competence must be determined by at least one other independent physician, and the consequences of his actions should be explained. Furthermore, he adds that only when the prisoner is assessed to be incompetent, force-feeding or artificial feeding could fall within the definition of a medical intervention in the sense of Article 32, as long as this intervention is necessary to avert serious risk to the health or safety of the prisoner or of others.[16] In my opinion, although force-feeding is considered a medical intervention in the sense of Article 32, the legislative history shows that Article 32 PPA is in principle

[15] *Kamerstukken II* 1994/95, 24 263, No. 6, p. 28.

[16] *Kamerstukken II* 1994/95, 24 263, No. 6, p. 28.

not applicable to situations of competent hunger strikers, as the hunger striker's wish to non-intervention in principle must be respected.

2.6. THE 1985 CIRCULAR OF THE STATE SECRETARY OF JUSTICE

A similar approach to the issue of hunger strike as expressed by the legislator in the 1990s can be found in the 1985 circular of the State Secretary of Justice Mrs Korte-van Hemel (hereafter: the 1985 circular), that probably inspired the legislative process in deciding on Article 32 and force-feeding almost ten years later. The 1985 circular was meant as a guideline for the treatment of prisoners on hunger strike. Nevertheless, circulars have a certain legal status, since they can be invoked by prisoners in legal proceedings.

The 1985 circular by Mrs Korte-van Hemel clarifies its point of view on force-feeding by discussing three different approaches to hunger strikes. The first is the most drastic: the physician applies force-feeding to the hunger striking prisoner, deciding so by mutual arrangement with the prison governor. This approach towards hunger strikers is rejected by the author of the 1985 circular.

Korte-van Hemel determined here that also more indirect ways of force-feeding, such as frequently confronting the prisoner with food, are also not allowed because of the manipulative character of such actions.[17] Still, in her view, it is not problematic that the prisoner is informed about the times for breakfast, lunch, dinner, tea and coffee.

The second approach towards force-feeding hunger strikers respects the hunger striker's decision to non-intervention while the hunger striker is competent, but considers force-feeding[18] legitimate if the prisoner is no longer competent, such as when he becomes comatose. This approach is also rejected by the author of the 1985 circular, if only because of the medical risks of intervention to a comatose patient. Intervention through the use of force-feeding when the prisoner is no longer competent can only be justified when there are circumstances which could be important for the uninformed hunger striker, and these circumstances could count against the risks which are concerned with the intervention.[19]

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17 "*Deze opvatting, die door de medische stand hier te lande wordt verworpen wijs ook ik van de hand. Ook een meer indirect wijze van dwangvoeding, bijvoorbeeld door de gedetineerde frequent voedsel voor te zetten, acht ik onjuist.*" Circulaire van de Staatssecretaris van Justitie, d.d. 4 december 1985, "Gedetineerde in hongerstaking", no. 799/385, *PI* 1986, Vol. 31, p. 49.

18 While in the 1985 circular the term force-feeding (*dwangvoeding*) is used, arguably the term artificial feeding (*kunstmatige voeding*) would be more correct here.

19 Circulaire van de Staatssecretaris van Justitie, d.d. 4 December 1985, "Gedetineerde in hongerstaking", No. 799/385, *PI* 1986, Vol. 31, pp. 49-50.

The third approach that is discussed is, in Korte-van Hemel's view, the most acceptable approach. This is the approach that takes into account the prisoner's wishes if he has explicitly declared he will refuse food. The government must aim to minimise the physical and mental damage to the hunger striker as much as possible, in so far as it is not intended with the hunger strike (such as bedsores). The ultimate consequence of the operation of this approach is that the hunger strike can result in the hunger striker's death. For this reason, the hunger striker's wish for non-intervention should be dealt with meticulously. The 1985 circular gives the following guidelines:

a) regular and step-by-step counselling of the hunger striker by a physician in which information is provided about the possible reversible and non-reversible consequences of his actions, so that the hunger striker can consciously decide to persist in his actions;

b) one or more declarations should be drafted (and preferably documented) by the prisoner, attended by the prison governor and physician, in which he declares that he is determined to continue his wish for non-intervention, if he becomes comatose as a result of his actions.

The 1985 circular furthermore advises the creation of a permanent team of independent experts for the treatment of prisoners in prolonged hunger strikes. If the physical condition of the hunger striker deteriorates, he can be transferred to the Custodial Medical Centre in Scheveningen for more specialised and equipped medical care.[20] The prisoner's consent to such transfer is not required.[21] Practice shows that such a transfer in many cases results in the end of the hunger strike, as the transfer gives the hunger striker the possibility to end his actions without a loss of face.

The opinion that prisoners on hunger strike must not be force-fed is, as mentioned in Ch. 5, § 4.4, shared by the Johannes Wier Foundation, a Dutch human rights organisation for health professionals. According to the Foundation, competent hunger strikers may never be force-fed, and physicians and other health personnel should never be involved in such practices. Their manual on the treatment of prisoners on hunger strike, which is currently being revised, is considered an in-depth elaboration of the 1985 circular.[22] This manual stipulates that every hunger striker has the right to medical guidance by a "trusted doctor" (*vertrouwensarts*): an independent physician, who is not affiliated with the prison or the other place of detention, in

[20] Circulaire van de Staatssecretaris van Justitie, d.d. 4 December 1985, "Gedetineerde in hongerstaking", No. 799/385, *PI* 1986, Vol. 31, p. 50.

[21] See, for example, a case before the Council for the Administration of Criminal Justice and Youth Protection (*Raad voor Strafrechtstoepassing en Jeugdbescherming*) d.d. 6 October 1999, No. 04/192/STA, about a transfer of a hunger striker to *Justitieel Complex Willem II* in Tilburg.

[22] Van Es, Van Ojen & Raat 2000. Translation in English: Johannes Wier Foundation 1995.

order to facilitate a relationship of trust. Since the 1970s there has been a tradition in the Netherlands for such trusted doctors to provide medical and psychological assistance to hunger strikers.[23] The manual of the Johannes Wier Foundation has long been widely used in Dutch prisons and asylum seekers' centres as an important source of guidance on the treatment of hunger strikers.

It can be concluded that Dutch policy leaves no room for force-feeding prisoners on hunger strike. The WMA Declarations of Tokyo and Malta are considered to be of great value of this respect. Kelk even acknowledges a right to a hunger strike.[24]

2.7. ADVANCE DIRECTIVES

The 1985 circular, and also the manual of the Johannes Wier Foundation, underline the importance of statements by the prisoner on what is to be done after he loses consciousness. A so-called advance directive can be useful in the hunger striking process as it forms a clear statement on the hunger striker's wishes to determine for himself when he is no longer competent to do so. Such an advance directive is an important tool for providing clarity: the hunger striker can describe in his own words what he kind of treatment he desires after he becomes incapable of deciding for himself. On the basis of Article 7:450, third paragraph, of the Dutch Civil Code, such an advance directive, drafted when the prisoner is still competent, must be respected. The health care provider may only derogate herefrom if he considers that there are sound reasons to do so. Fatal consequences of respecting the advance directive, or family members opposing the patient's wishes, do not qualify as sound reasons in this respect. To invoke the clause derogating from the advance directive, there must be special circumstances, for example that the original goal of the hunger strike has yet been reached, without the hunger striker knowing.[25] The advance directive should be included in the medical file of the prisoner involved. The Johannes Wier Foundation emphasises in its manual that such an advance directive does not mean that the hunger striker must no longer be counselled and informed about the consequences of his actions. Moreover, parties surrounding the hunger striker must be careful that he does not tie himself down to this advance directive at too early a stage. It should be made clear that the hunger striker is free to change his advance directive as a result of a change of opinion during the hunger strike.[26]

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23 This doctor of confidence is selected through the "Network of trusted doctors" (*Netwerk Vertrouwensartsen*), administered by the Johannes Wier Foundation.

24 Kelk 2008, p. 289.

25 Gevers 2000, p. 1010.

26 Van Es, Van Ojen & Raat 2000, p. 21.

2.8. POLICY CHALLENGED: THE CASE OF *VOLKERT VAN DER G.*

The assassination of politician Pim Fortuyn on 6 May 2002 caused a great deal of commotion and enormous media coverage in and outside the Netherlands. Many perceived his killing as a direct attack on democracy. At the moment of his assassination, Pim Fortuyn was a well-known Dutch politician and the first candidate on the list of the Pim Fortuyn List (*Lijst Pim Fortuyn*) for the imminent parliamentary elections on 15 May 2002. Shortly after the murder, a suspect was arrested: Volkert van der G. The suspect was taken into custody in Over Amstel prison. For fear of Volkert van der G. committing suicide, he was placed under permanent camera monitoring. On 12 July 2002, Volkert van der G. started a hunger strike, *inter alia* against this permanent monitoring. He decided to refuse food, and drank solely fruit juice and sugared coffee and tea. He drew up an advance directive, stating that he refused to be treated against his will, even when his condition became critical.

From the end of August 2002 in media and politics commotion was created by Volkert van der G.'s hunger strike, because from on that moment he could die as a result of his actions. The question of the possibilities to force-feed Volkert van der G. became the topic of heated discussions in the streets and media. Should the alleged murderer of Pim Fortuyn be allowed to starve himself to death? His death would mean that his trial could not take place, since a trial ends when the suspect dies. In addition, his death would lead to the loss of valuable information on his motives for his action, and the question of whether he worked alone or for some organisation would remain unanswered. In society and media, opinions were voiced that Van der G. should be force-fed when his situation would become life-threatening to prevent him from taking his own life as a result of his action.

By the end of August, the question of the force-feeding of Volkert van der G. also became prominent on the political agenda when two Members of Parliament, Van Heemst and Albayrak, posed parliamentary questions to the Minister of Justice on the possibility of force-feeding Volkert van der G. Minister of Justice Donner responded to these questions on 22 August 2002, referring to the 1985 circular and Article 32 PPA. With regard to the latter, he remarked that Article 32 provided the possibility to oblige a prisoner to acquiesce to having a specific medical intervention carried out on him, and that the application of food and/or fluids could be considered a medical intervention in the sense of this Article. He furthermore noted that the decision to apply Article 32 PPA is taken by the governor of the prison, when in the opinion of a physician this intervention is necessary to avert serious risk to the health or safety of the prisoner or of others. The actual application is performed by a physician. In such a situation, the principles of the 1991 WMA Declaration of Malta act as a guidance. This was nothing new. The surprise element can be found in the following statement by Minister of Justice Donner

> "In deciding on force-feeding, more interests and considerations involved than only the will and competence of the person must be taken into account. I feel no need

> to act in anticipation of possible interests and considerations before these actually occur. Still, I do want to make clear that I attach much value to uninterrupted court proceedings."[27]

From this, it can be concluded that Minister Donner did not (yet) wanted to elaborate on the question of whether forced medical treatment would be performed to intervene in the hunger strike of Volkert van der G. Still, by emphasising the value he attached to uninterrupted court proceedings, he seemed to leave the possibility for force-feeding open. In this, he joined the majority in the Lower House that at that moment was of the opinion that Volkert van der G. had to be force-fed if necessary to prevent him from dying as a result of his hunger strike. According to the political parties CDA, LPF, VVD and Leefbaar Nederland, an exception on the Dutch policy on hunger strikers, which promoted the right to self-determination of prisoners on hunger strike and rejected force-feeding, had to be made in the case of Volkert van der G. According to these parties, the Dutch legal order was so shocked by the murder on Pim Fortuyn that is was of the utmost importance that Volkert van der G. was brought before court.[28]

It is remarkable that Minister Donner, in addition to the demands laid down in Article 32 PPA, introduced a new criterion for the application of this Article: the interest of uninterrupted court proceedings. By permitting him to starve to death, the suspect would be given the opportunity to "avoid" standing trial, and severely affect the pending case against him. It can be concluded that Minister Donner placed great value on the fact that Volkert van der G. lived to stand trial, so that justice could run its course.

A little more insight in Minister Donner's opinion on this matter was provided by his answers in response to parliamentary questions from Members of Parliament Teeven and De Wit on 9 December 2002.[29] The answers to these questions were, as far as the issue of force-feeding was concerned, identical. In his response to the questions from Member of Parliament Teeven, Minister Donner elaborated on the three phases in the decision-making process on the application of Article 32 PPA as described in the Explanatory Memorandum (see § 2.3 of this chapter): the first

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27 "*Bij een beslissing over de gedwongen voeding zijn derhalve meer belangen en overwegingen aan de orde dan alleen de wil en wilsbekwaamheid van de betrokkene. Ik heb geen behoefte om vooruit te lopen op de eventuele afwegingen terzake, voordat deze daadwerkelijk aan de orde is. Wel hecht ik eraan duidelijk te maken dat ik veel belang hecht aan een ongestoorde rechtsgang.*" "Volkert van der G.", *Aanhangsel van de Handelingen II* 2001-2002, No. 1547 Herdruk.

28 "Mogelijk dwangvoeding voor Van der G." (*Possible force-feeding for Volkert van der G.*), 21 August 2002, <http://www.nu.nl/algemeen/3228/mogelijk-dwangvoeding-voor-van-der-g.html> (last accessed on 3 February 2012).

29 "Volkert v/d G. en de Penitentiaire Beginselenwet", *Aanhangsel van de Handelingen II*, 2002-2003, No. 473 and "Het standpunt van de Inspectie voor de Gezondheidszorg over dwangvoeding Volkert van der G.", *Aanhangsel van de Handelingen II*, 2002-2003, No. 474.

phase is the medical judgment as to whether medical intervention is necessary to avert serious risk to the health or safety of the prisoner or others. The second phase is the decision by the prison authorities to oblige a prisoner to acquiesce to having a specific medical intervention carried out on him. The third phase is the execution of Article 32 PPA; the carrying out of the medical intervention by a physician or, on his instructions, by a nurse. With regard to the third phase, Minister Donner stated that the medical decision to apply force-feeding is different to the decision to decide to apply force-feeding by the prison governor: the physician must decide whether he can apply this treatment in a responsible way, and he is guided by his medical standards, including the WMA Declarations of Tokyo and Malta.

Particularly interesting is his statement on the decision-making procedure in the second phase, the decision by the prison authorities to decide on the forced medical treatment

> "The decision to order medical treatment […] concerns a public action that must be motivated and inspired by considerations of the public interest. An explicit refusal of medical treatment or the lack of consent to this has to be balanced against the public interest."[30]

Here, Minister Donner introduced a new consideration in considering whether to apply Article 32 PPA: the public interest. Accordingly, not only the will of the hunger striker must be considered (as stated in the 1985 circular and the Explanatory Memorandum with Article 32), but this must be balanced against the public interest. Where Minister Donner, in answers to parliamentary questions from Van Heemst and Albayrak, mentioned the interest of "uninterrupted court proceedings", this seems to have been part of a broader criterion, i.e. the "public interest". Accordingly, Minister Donner saw no legal impediments to force-feeding prisoners on hunger strike on the basis of Article 32 PPA. He noted that, in his opinion, neither the Constitution nor the ECHR stood in the way of force-feeding prisoners on hunger strike. He mentioned that the ECtHR has ruled in its case law that force-feeding in principle does not violate Articles 3 and 8 ECHR. He furthermore mentioned Article 2 ECHR, which under certain circumstances imposed positive obligations for the authorities to act in order to save the life of prisoners. Furthermore, he stated that with regard to prisoners on hunger strike, two responsibilities could be distinguished: 1) the responsibility of the Minister of Justice for the protection

[30] "*Het besluit om tot een medische handeling onder dwang over te gaan […] betreft een publiek handelen dat gemotiveerd en gedragen moet worden door overwegingen van publiek belang. Een uitdrukkelijke weigering om een medische handeling te ondergaan of het ontbreken van instemming daarmee dient te worden afgewogen tegen het publiek belang.*" "Volkert v/d G. en de Penitentiaire Beginselenwet", *Aanhangsel van de Handelingen II*, 2002-2003, No. 473 and "Het standpunt van de Inspectie voor de Gezondheidszorg over dwangvoeding Volkert van der G.", *Aanhangsel van de Handelingen II*, 2002-2003, No. 474.

of the public interest and 2) the responsibility of the physician for the well-being of his patients. In the view of Minister Donner, these responsibilities should be clearly distinguished.

The part in which he goes into the first responsibility, that of the Minister of Justice for the protection of the public interest, is especially interesting. In this part, he stated that this responsibility

> "is reflected in the authority attributed to the governor to oblige the prisoner to accept medical treatment, i.e. force-feeding. The protection of the public interest [by the Minister of Justice] includes the protection of the interests of prisoners entrusted to his care and the protection of the legal order."[31]

He furthermore noted that

> "the protection of legal order may include guaranteeing uninterrupted court proceedings, which, considering the nature and severity of the offence, are of great importance for the recovery of a legal order that has been seriously shaken by the offence, and the effects of the death of a hunger striker on society. In deciding on force-feeding more interests and considerations play a role than only the will and the competence of the concerned prisoner on hunger strike."[32]

It can be concluded that, according to Minister of Justice Donner, the public interest included protection of the legal order, which consisted of guaranteeing uninterrupted court proceedings when necessary for the recovery of legal order after an offence that has seriously shocked society. Besides the interests of the hunger striker, the public interest has to be taken into account when considering force-feeding. In Donner's opinion, the death of Volkert van der G. would cause much turmoil, and have a huge impact on society. It can be further concluded that, according to Minister Donner, in deciding in the application of Article 32 PPA in this case, the prison governor has to assess whether the legal order had been seriously shaken by the offence and seek uninterrupted court proceedings. Furthermore, to the prison governor has to take the hunger striker's will and his express wishes into account, and he has to

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31 "*De verantwoordelijkheid van de minister van Justitie komt tot uitdrukking in de aan de directeur van de inrichting geattribueerde bevoegdheid om de gedetineerde te verplichten een geneeskundige handeling te gedogen, in casu dwangvoeding. De bescherming van het publiek belang omvat de bescherming van de belangen van de aan de zorg van Justitie toevertrouwde gedetineerden en de bescherming van de rechtsorde.*"

32 "*Bij de bescherming van de rechtsorde kan worden gedacht aan de verzekering van een normale rechtsgang die, gelet op de aard en de ernst van het delict en de zeer ernstige geschoktheid van de rechtsorde, van groot belang is voor herstel van de samenleving van die geschoktheid, en aan het effect van een eventuele dood van de hongerstaker op de samenleving. Bij een beslissing over dwangvoeding zijn dus meer belangen en overwegingen aan de orde dan de wil en de wilsbekwaamheid van de betrokken gedetineerde hongerstaker.*"

estimate the possible effects of the hunger striker's death on society. This assessment framework for the prison governor is substantially broader than explained in the Explanatory Memorandum of the PPA and shown in the 1985 circular. Minister Donner seemed to be aware of this, and announced that he would elaborate on the new framework of assessment with Article 32 PPA in a circular to be published.[33]

This statement has invoked a storm of reaction. The Johannes Wier Foundation (see Ch. 5, § 4.4) stated publicly that physicians must never cooperate in force-feeding practices. They emphasised that the application of feeding against the will of the person, even when intended to benefit the person, must be considered as a form of assault. Besides this, they stated that force-feeding is risky and will often not (or no longer) be able to save the life of hunger striker as the hunger strike endures. Furthermore, the Johannes Wier Foundation emphasised the importance of the WMA Declarations of Malta and Tokyo, which oppose force-feeding competent hunger strikers, and noted that the Royal Dutch Medical Association was actively involved in the creation of these documents. The Johannes Wier Foundation also stressed the meaning of Article 3 ECHR and Article 11 of the Dutch Constitution which prohibit serious breaches on the hunger striker's physical integrity, and referred to the 1985 circular that prescribes that the hunger striker's decision to refuse food must be respected.[34]

The Dutch Health Care Inspectorate expressed its view in a letter by J.H. Kingma, the Inspector General of Health Care, directed to the Royal Dutch Medical Association (*Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst*).[35] In it, he stated that the Healthcare Inspectorate would test the actions of physicians involved in force-feeding competent hunger strikers against treaty law and (constitutional) legal norms, as well as against universally accepted (international) rules of private organisations and other current legal opinion. In respect of this, Kingma stated that the behaviour of physicians for the benefit of someone in custody who has not yet been sentenced should not be any different to the treatment of a free person, and should be in accordance with Articles 2 and 3 ECHR, Articles 10, 11 and 15 of the Dutch Constitution, secondary legislation such as the medical treatment agreement as codified in the Civil Code, and the WMA Declarations of Tokyo and Malta. According to Kingma, international and Dutch legal and medical-ethical norms left no room for force-feeding competent hunger strikers, as their point of departure is respect for the freedom to decide to refuse food and/or fluids. Furthermore, he

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33 Because these additional interests as formulated by Donner are predominately societal and thus transgress the interest of the prisoner and the prison at large, in my opinion the question should be asked whether the assessment of these interests was best left to the discretion of the prison governor. I will elaborate on this aspect in Ch. 7, § 5.2.

34 Letter to the management board of the Royal Dutch Medical Association and the Parliamentary Standings Committee on Justice and Public Health (*de Vaste Kamercommissies Justitie en Volksgezondheid*) d.d. 23 August 2002.

35 Letter d.d. 2 September 2002.

emphasised that physicians must not act against their conscience when pressured to do so by public opinion or third parties. The physician must act according to his own, independent professional judgment that is formed in conformity with the state of the art, that meets his professional standards and that meets the relevant legal demands. Kingma notes furthermore that a physician must only apply Article 32 PPA when established by a physician as being necessary to avert serious risk for the health or safety of the prisoner or others, and added that

> "[i]n principle, such treatment may only be performed when the patient because of his mental disorder causes a severe risk to himself, to others or to the order in the prison, and this danger cannot be averted in other, less invasive ways. If no mental disorder exists that causes the danger for others or the order in the prison, the individual's interest must serve as a guideline for the physician's treatment."[36]

In addition, Kingma underlined what already had been stated in the 1985 circular, and emphasised the medical risks involved in force-feeding and artificial feeding once the hunger striker has already lapsed into a coma.

From this letter by the Dutch Health Care Inspectorate, it can be concluded that, although Minister Donner determined that Volkert van der G. should be force-fed when necessary, physicians who are willing to apply this medical treatment face disciplinary proceeding before the Central Medical Disciplinary Tribunal (*Centraal Medisch Tuchtcollege*). From a radio interview with Jacques Lucieer, chief medical inspector for the Dutch Health Care Inspectorate, it is clear that behind the scenes the Dutch Health Care Inspectorate made clear to the Ministry of Justice that they would in fact start such proceedings against physicians who participated in force-feeding.[37] As demonstrated in Ch. 6, § 2.4, physicians cannot be forced to participate in medical treatment. Nevertheless, the prison governor needs a physician to examine the hunger striker to determine whether the medical treatment is necessary to avert serious risk to the health or safety of the prisoner or of others (cf. Article 32 PPA), and to actually apply force-feeding. After all, the Individual Healthcare Professions Act (*Wet beroepen in de individuele gezondheidszorg*)[38] determines after all that only physicians and midwives are authorised to perform catheterisations (Article

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36 "*In beginsel zal een dergelijke handeling slechts plaatsvinden indien de patiënt op basis van een geestesstoornis een ernstig gevaar vormt voor zichzelf, anderen of de orde in de penitentiaire inrichting en dit gevaar niet op andere, minder ingrijpende wijze kan worden afgewend. Indien er geen sprake is van een geestesstoornis op grond waarvan gevaar wordt veroorzaakt voor anderen of de orde in de inrichting, dient het belang van het individu leidraad te zijn voor het handelen van de arts.*"

37 Radio interview in '*De Ochtenden*', d.d. 5 September 2010.

38 This act regulates the provision of care by professional practitioners, focusing on the quality of professional practice and patient protection. To prevent unacceptable health risks to the patient resulting from a lack of professional competence, certain procedures are specifically excluded and may only be performed by authorised professional practitioners. <http://english.minvws.nl/en/artikelen/ibe/the_individual_health_care_professions_act.asp> (last accessed on 3 February 2012).

36, fourth paragraph) and give injections, which includes the insertion of a drip (Article 36, fifth paragraph). Although a physician participating in force-feeding faces disciplinary proceedings before the Central Medical Disciplinary Tribunal, several physicians stated publicly that they would be willing to force-feed Volkert van der G. if asked. These were two Members of Parliament for the Pim Fortuyn list, Gerlof Jukema (lung specialist) and Milos Zvonar (anaesthesiologist). A similar opinion that Volkert van der G.'s life should be saved even when against his express wishes, was proposed by A.J. Postmes (former forensic physician) in a letter sent to the medical journal *Medisch Contact*.[39]

The Royal Dutch Medical Association has long since been an active member of the WMA, and, in this way, has committed itself to the Declarations of Tokyo and Malta. In a public statement in response to the hunger strike of Volkert van der G., the Royal Dutch Medical Association aligned itself with the view of the Dutch Health Care Inspectorate as shown by J.H. Kingma, strongly advising physicians not to cooperate with force-feeding competent hunger strikers. Essential points in their policy are the patient's right to self-determination and the professional autonomy of the physician, which form the core of the trust of patients in physicians, according the Association. The rule in medical ethics that, for medical interventions, the patient's consent is required is in accordance with the constitutional right to physical integrity. In the case of a prisoner, the PPA is also involved. Article 32 PPA provides the governor, under certain circumstances, the possibility to oblige a prisoner to agree to having a medical intervention carried out on him, as acknowledged by the Royal Dutch Medical Association. Still, "even when this stipulation would provide a basis for a decision to force-feed, this does not alter the fact that a physician must only be led by medical-professional norms and that he must take the decision in a autonomous way", according to the Royal Dutch Medical Association. As a result, the physician must decide for himself whether to apply force-feeding or not, on the basis of his medical-professional autonomy. In deciding to force-feed, he must only be governed by the patient's interests, and not by other third party interests. In deciding, physicians can find guidance in principles of medical ethics, such as codified in the WMA Declarations of Tokyo and Malta. In the case of Volkert van der G., the Royal Dutch Medical Association saw no reason to deviate from this general principle. According to them, social and political pressure should not influence the physician. For this reason, it strongly advises Dutch physicians not to cooperate in force-feeding competent hunger strikers, also mentioning the medical risks of force-feeding, in line with the view of the Dutch Health Care Inspectorate.[40]

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39 Postmes 2002.

40 Royal Dutch Medical Association, 'KNMG: niet meewerken aan dwangvoeding gedetineerden' *(Royal Dutch Medical Association: do not participate in force-feeding prisoners*), 6 September 2002. Published as Royal Dutch Medical Association 2002-I.

In reaction to Minister Donner's view on force-feeding also the National Association for Penitentiary Health (*Landelijke Vereniging voor Penitentiaire Geneeskunde*) and the Association for Health Law (*Vereniging voor Gezondheidsrecht*) also voiced their opinions on this issue. In a press release of 12 September 2002, the Association for Health Law stated that force-feeding in a well-considered hunger strike is unacceptable, since it is part and parcel of medical ethics and the physician's professional standards that no medical intervention can be carried out if a mentally competent person has unambiguously rejected such intervention.[41] The National Association for Penitentiary Health also stated that its members should not cooperate in force-feeding practices, since this would go against their professional code. Secretary of the National Association for Penitentiary Health J.G.J. de Boer even deemed participation in force-feeding practices as torture. Similar opinions – declaring force-feeding in competent hunger strikers unacceptable – were expressed in editorial commentaries by Gevers and Crul.[42]

In conclusion, Minister Donner declared himself willing to force-feed Volkert van der G. if necessary. This was not only reflected by his answers to parliament, but he also voiced this opinion several times in the media.[43] This is remarkable, considering the fact that Van der G. was declared competent by two trusted doctors, two independent psychiatrists and the prison physician, and he even signed a declaration of non-intervention.[44] Force-feeding was never applied, as Volkert van der G. stopped his hunger strike after seventy days. No precise reasons for the ending of his hunger strike were made public, but he announced that he "had concrete indications that his custodial conditions would improve."[45] As a result, the permanent camera monitoring disappeared from his cell, and on 27 March 2003, his trial started.[46] With the end of the hunger strike, the question of whether force-feeding would actually be applied remained unanswered. With this, the discussion to the

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41 Association for Health Law, 'Bestuur Vereniging voor Gezondheidsrecht: dwangvoeding bij hongerstaking onaanvaardbaar' (*Board Association for Health Law: force-feeding in case of hunger strike unacceptable*), 12 September 2002. The Association for Health Law is an association of about 800 members, for the greater part lawyers, who are interested in the pursuit of scholarship in the field of health law.

42 Crul 2002 and Gevers 2002.

43 'Dwangvoeding niet uitgesloten' (*Force-feeding not impossible*), *NRC Handelsblad* 22 August 2010, 'Donner: voeding onder dwang mag' (*Donner: force-feeding is permissible*), *NRC Handelsblad* 7 September 2010, and Oranje 2002-II.

44 Oranje 2002-I.

45 'Volkert van der G. stopt hongerstaking' (*Volkert van der G. stops hunger strike*), *NRC Handelsblad* 19 September 2002.

46 Volkert van der G. appealed against this permanent camera monitoring several times. The Council for the Administration of Criminal Justice and Youth Protection ruled on 12 September 2002 that the permanent camera monitoring on the basis of an emergency measure (of 5 July 2002) was legitimate: Beroepscommissie RSJ d.d. 12 September 2002, No. 02/1580/GA. Volkert van der G. also appealed to the ECtHR, alleging a violation of Articles 3 and 8 ECHR. The ECtHR decided in

legitimacy of force-feeding prisoners on hunger strike also fell silent. The criteria for the assessment of the application of Article 32 PPA mentioned in the answers to parliamentary questions – the 'public interest', the interest of 'uninterrupted court proceedings', and 'the effect of the hunger striker's death on society' – are extremely vague and need further specification. Minister Donner was aware of this, and announced that he would elaborate on them in a new circular. To the best of my knowledge, this circular, announced in 2002, has not yet appeared. For this reason, the framework of assessment for the application of Article 32 PPA by the prison governor remains unclear. Because of this, the Dutch Section of the International Commission of Jurists (*Nederlands Juristen Comité voor de Mensenrechten*) has recommended clarifying the framework within which the physician and director have to make their decision on force-feeding a hunger striker.[47] In my opinion, the case of Volkert van der G. showed that, although the possibility to force-feed prisoners in Dutch legislation and policy were non-existent, this policy is not so absolute as it may seem. In politically delicate cases in particular, the opinion that no force-feeding should applied to hunger strikes is hotly debated.

2.9. THE CASE OF *ŠEŠELJ*

A case in which the question of force-feeding became topical again in the Netherlands was that of alleged Serbian war criminal Šešelj in 2006 before the ICTY in The Hague. I already elaborated on this case in Ch. 5, § 2.1.9. Just as with case of Volkert van der G., force-feeding was required mainly to preserve the hunger striker's life and ensure the administration of justice. In December 2006, the Dutch authorities were faced with an order from the ICTY's Trial Chamber that ordered them "to provide medical services under the Agreement – which may, in the case of medical necessity, include intervention such as drip-feeding – with the aim of protecting the health and welfare of the Accused and avoiding loss of life".[48] If, after this intervention, the hunger striker would show determination to continue his hunger strike and remain determined not to be force-fed, however, this should be respected and no further force-feeding be applied. The actual disposition left considerable discretion to the Dutch authorities, and confronted them with the difficult – if not impossible – task of applying the level of force-feeding necessary for lifesaving purposes that would

a decision on admissibility that these Articles had not been violated. ECtHR 1 June 2004, *Volkert van der Graaf v the Netherlands,* App. No. 8704/03. See also Ch. 7, § 5.3.1.

47 Wijnakker 2006, p. 448. The Dutch Section of the International Commission of Jurists furthermore recommended that in this connection physicians' organisations must be consulted on the matter and their consideration must be taken into account when creating the new policy on hunger strikes.

48 *Urgent Order to the Dutch Authorities Regarding Health and Welfare of the Accused*. Trial Chamber, 6 December 2006.

not contradict "internationally accepted standards of medical ethics or binding rules of international law" (see Ch. 5, § 2.1.9).[49]

Although the matter was only dealt with in an explanatory sense in the cabinet (as Šešelj ended his hunger strike the day as the order appeared), in a response to parliamentary questions by Members of Parliament Çörüz and van Haersma Buma, the Minister of Justice and the Minister of Foreign Affairs stated that on the basis of Article 29, second paragraph, of the Statute the Dutch authorities must "comply without undue delay with any request for assistance or an order issued by a Trial Chamber". In their opinion, the ICTY is responsible for the welfare of the suspect it has taken into custody, and possible force-feeding would also take place under the responsibility of the ICTY. The "UN Detention Services and Facilities Agreement" determines that the Dutch Judicial Institutions Service (*Dienst Justitiële Inrichtingen*) supplies the ICTY with prison workers and a physician. According to the Dutch authorities it is not they but the ICTY that decides in cases of the medical treatment of prisoners. The Dutch authorities therefore concluded that the ICTY itself remains responsible for the treatment of prisoners, including the decisions about intervention in a hunger strike, and the physician involved should decide according to his own medical standards.[50]

Although the Dutch authorities were of the opinion that the treatment of prisoners under the ICTY was strictly a matter for the ICTY and showed their willingness to cooperate to enforce the force-feeding order, Sluiter has expressed doubts about the legal basis for the issuance of the order and the ensuing duty to cooperate. According to him, although the host State indeed has a duty to provide medical services, there is insufficient grounds to extend these obligations to the particular situation of a hunger strike in his opinion. Although it may be argued that force-feeding assists the ICTY in prosecution of the accused, as the accused must be kept alive with a view to ensuring the continuation of the trial, this is a very extensive interpretation of Article 29 of the Statute, as this Article is aimed to govern matters of cooperation and legal assistance, such as the identification and location of persons, the service of documents or the surrender or the transfer of the accused to the International Tribunal.[51] In my opinion, this order constitutes a case for the Dutch authorities to autonomously decide upon, since it leaves considerable discretion to the host State (see Ch. 5, § 2.1.9). Dutch legislation seems to provide no possibility for force-feeding prisoners on hunger strike (although in 2002 Minister Donner stated that Article 32 PPA provides the possibility to force-feed), and Dutch medical associations have repeatedly stated that they strongly oppose to force-feeding competent prisoners on hunger strike. Moreover, physicians who are willing to apply this medical treatment face disciplinary proceedings before

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49 Ibid.

50 *Aanhangsel van de Handelingen II* 2006/07, No. 956.

51 Sluiter 2007, pp. 531-532 and personal communication with Göran Sluiter d.d. 6 January 2011.

the Central Medical Disciplinary Tribunal (as discussed in the previous sections). Although Šešelj refused the assistance of Dutch or tribunal physicians (he agreed to a team of physicians from Serbia, Russia and France) it is possible that the Dutch physician could have been asked to force-feed Šešelj if his situation were to become life-threatening. In my opinion it is highly doubtful that this physician would be willing to participate in force-feeding Šešelj.

It can be concluded that the force-feeding order itself, as well as the execution of it by the host State is rather problematic. Despite these problems, the Dutch government received the order rather uncritically.[52]

2.10. LEGAL REMEDY

Currently, in the Netherlands, a couple of procedures can be invoked when a prisoner on hunger strike is faced with the prospect of being force-fed, and wants to prevent it from occurring. As stated in § 2.3 of this chapter, on the basis of Article 32 PPA the governor may oblige a prisoner to accept having a specific medical intervention carried out on him. If the prison governor decides to apply force-feeding on the basis of this Article, according to Dutch penal law two procedures can be invoked. The first is the "normal" complaints procedure of Article 60 PPA concerning the decision taken by, or on behalf of, the governor. The second procedure (which can combined with an action on the basis of Article 60 PPA) is an appeal against the medical intervention as ordered by the prison director on the basis of Article 28 et seq. of the Penitentiary Order. In addition, a prisoner can start interim injunction proceedings to claim that the State be barred from force-feeding him. I will explore these three procedures below.

For complaints about the decision by the prison governor to oblige a prisoner to acquiesce having a specific medical intervention carried out on him, the "normal" complaints procedure of Article 60 PPA is applicable. Article 60 PPA determines that prisoners may file a complaint with the Complaints Committee (*beklagcommissie*) concerning decisions taken by, or on behalf of, the governor.[53] On the basis of the complaints procedure of Article 60 PPA the prisoner can appeal to this decision.

The Complaints Committee is composed of members of the Supervisory Committee (*Commissie van Toezicht*). This Supervisory Committee consists of no fewer than six members and no more than a maximum number to be specified by the Minister of Justice. Its composition must represent the widest possible range of interests, but must include in any event at least one member of the judiciary, a

[52] As noted by Sluiter 2007, p. 532.

[53] Such decision as referred to in the first paragraph may also be, according to the second paragraph, be the same as an omission or refusal to take a decision. A decision shall be deemed omitted or refused if it is not taken within the statutory term, or, if this is lacking, within a reasonable term.

lawyer, a medical practitioner and a social work expert (Article 11 of the Penitentiary Order). When dealing with the complaints, the Complaints Committee consists of three members, and, if possible, is chaired by a member of the judiciary (Article 62 PPA and Article 18 of the Penitentiary Order). A complaint on the basis of Article 60 PPA must be filed with the Complaints Committee of the institution where the decision against which the complaint is being made was taken, and the complaint must mention as accurately as possible the decision to which the complaint relates and the reasons for it (Article 61, paragraphs 1 and 3, PPA). Furthermore, the complaint must be filed no later than the seventh day after the day on which the prisoner is notified of the decision against which he wishes to complain (paragraph 5). Article 67, first paragraph, PPA determines that the Complaints Committee shall deliver a resolution as soon as possible, though in any case within a period of four weeks from the date on which the complaint was received. (In exceptional circumstances, the Complaints Committee may extend this period by up to a further four weeks, in which case the governor and the complainant shall be notified of this extension.)

The Complaints Committee can declare the complaint as wholly or partly inadmissible, unfounded or founded (Article 68, paragraph 1, PPA). Article 68, paragraph 2, states that if the Complaints Committee is of the opinion that the decision to which the complaint relates: a) is contrary to a statutory regulation in force in the institution or a stipulation binding upon all parties of a treaty in force in the Netherlands; or b) must, in weighing up all relevant interests, be deemed unreasonable or unfair, it shall declare the complaint founded and annul all or part of the decision.

On the basis of Article 69 PPA, the governor and the complainant may appeal against the Complaints Committee's resolution by entering an appeal to the Appeals Committee comprised of three members appointed by the Prison Section. This appeal must be filed no later than the seventh day after receipt of a copy of the complaint resolution or after receipt of the oral notification of the resolution. The Appeals Committee is comprised of three members appointed by Council for the Execution of Criminal Justice and Youth Protection (*Raad voor Strafrechtstoepassing en Jeugdbescherming*), assisted by a secretary. There is no fixed term for the Appeals Committee to decide, although Article 71 PPA prescribes that "[t]he Appeals Committee shall deliver a resolution as soon as possible". On the basis of Article 66 PPA, the chairman of the Appeals Committee may at the complainant's request, and after hearing the governor, suspend all or part of the implementation of the decision to which the complaint relates.

In Dutch penal law, a special provision has been created for complaints concerning medical treatment, codified in Articles 28-34 of the Penitentiary Order. On the basis of this procedure, a prisoner may enter an appeal against a medical intervention by a physician that was ordered by the prison director. Before filing a notice of appeal, the prisoner must make a written request to the Medical Adviser of the Ministry of Justice to mediate in the dispute. This request should be filed no later than the

fourteenth day after the day on which the medical intervention against which the complaint is directed took place (Article 29 of the Penitentiary Order). The Medical Adviser gives the person involved the opportunity to clarify the complaint in writing or orally, he has the authority to examine the prisoner's medical file, and he shall endeavour to reach a solution acceptable to both parties within four weeks (Article 29 of the Penitentiary Order, paragraphs 2-4). If this mediation does not succeed, appeal is possible by a Committee appointed by the Council for the Execution of Criminal Justice and Youth Protection, which consists of three members, a legal expert and two physicians, assisted by a secretary (Article 30 of the Penitentiary Order). Such a complaint can be combined with a complaint on the decision by the governor on the basis of Article 60 PPA.[54]

As shown above, if a prison governor were to decide to apply force-feeding on the basis of Article 32 PPA, on the basis of Dutch penal law, two procedures could be invoked by the prisoner faced with force-feeding: the normal complaints procedure of Article 60 PPA concerning the decision taken by, or on behalf of, the governor, and an appeal against the medical intervention as ordered by the prison director on the basis of Article 28 et seq. of the Penitentiary Order. These procedures are only possible if the prison governor has decided on the issue of force-feeding. In most cases, a decision by the prison governor will not be made until the issue of force-feeding becomes urgent, i.e. when the situation becomes critical. After all, the governor may only oblige a prisoner to accept having a specific medical intervention carried out on him on the basis of Article 32 PPA if "necessary to avert serious risk to the health or safety of the prisoner or of others". Barring situations in which the governor decides on the issue of force-feeding almost immediately after the beginning of the hunger strike, in most cases this procedure will be too time-consuming, especially if appeal is to go to the Appeals Committee. Because of the rapid evolving nature of a hunger strike, assessment of the legitimacy of force-feeding may require an expeditious procedure. As long as no decision by the governor on the basis of Article 32 PPA is taken, a prisoner can start interim injunction proceedings (*kort geding*) to bar the State from force-feeding him. Such proceedings can be used to prevent the State from committing a wrongful act under Article 6:162 of the Dutch Civil Code. Interim injunction proceedings are only allowed if no other legal procedure with sufficient safeguards is open to the claimant that may yield a similar result in the short term. The complaints procedure on the basis of Article 60 PPA is qualified as such a legal procedure. Accordingly, interim injunction proceedings are only allowed if a complaints procedure on the basis of Article 60 PPA has not yet started.

54 De Jonge & Cremers 2008, p. 194.

2.11. CONCLUSIONS

The right to self-determination is codified in Articles 10 and 11 of the Dutch Constitution (*Grondwet*). The principle that competent patients have to consent before medical treatment can be performed is laid down in the medical treatment agreement, as codified in Article 7:450 of the Civil Code. Forced medical treatment is possible with persons who are compulsorily admitted to a psychiatric hospital, but only when laid down in the treatment plan, or when necessary to avert immediate risk. Compulsory admission to a psychiatric hospital on the basis of the Psychiatric Hospitals Act is possible for food refusers who suffer from a mental disorder, but is not likely to be applied in a hunger strike. The stipulations of the medical treatment agreement, as, *inter alia,* laid down in Article 7:450 of the Civil Code, are not only applicable to patients who are free, but also apply to prisoners. Nevertheless, restrictions on the constitutional right to physical integrity can be imposed on the basis of the provisions contained in Chapter VI of the PPA. A legal basis for the application of a medical intervention without the prisoner's consent can be found in Article 32 PPA. On the basis of this Article, the prison governor may decide that a prisoner has to accept that medical treatment is administered without his consent, to avert serious risks to the prisoner's own or others' health or safety. If a prison governor were to decide to apply force-feeding on the basis of Article 32 PPA, according to Dutch penal law, two procedures could be invoked by the prisoner: the normal complaints procedure of Article 60 PPA concerning a decision taken by, or on behalf of, the governor; and an appeal against the medical intervention as ordered by the prison director on the basis of Article 28 et seq. of the Penitentiary Order. These procedures are only possible if the prison governor has decided on the issue of force-feeding. Before this moment, the prisoner can start interim injunction proceedings to bar the State from force-feeding him. The decision by the prison governor to order forced medical intervention does not create an obligation for the medical professional to act. If intervention is needed, and if so what intervention is to be applied is left to the judgment of the physician, who decides on the basis of his professional standards. Although the application of food and/or fluids can be considered "medical intervention" in the sense of Article 32 PPA, its legislative history shows that the legislator has given explicit consideration to the situation of force-feeding prisoners on hunger strike, and has stated that Article 32 PPA is, in principle, not applicable to situations of competent hunger strikers, and in such cases the hunger striker's wish to non-intervention must be respected. A similar approach is reflected in the 1985 circular. If the hunger striker has lapsed into a coma and an advance directive exists that clearly expresses the wish not to be fed in such circumstances, drawn up when the hunger striker was still competent, this advance directive must be followed. It might be concluded that the possibility of force-feeding prisoners in the Netherlands is non-existent.

The case of Volkert van der G., however, shows that this policy is not as absolute as it may seem. In 2002, Minister Donner and a majority in the Lower House showed willingness to force-feed Volkert van der G. to prevent him from dying as a result of his prolonged hunger strike. Minister Donner saw possibilities for force-feeding under Article 32 PPA, stating that, in deciding on the application of this Article, more interests than only the will and competence of the suspect are involved. He introduced a new consideration in assessing the application of Article 32 PPA: public interest. Public interest includes the protection of legal order, which consists of "guaranteeing uninterrupted court proceedings, which, because of the nature and severity of the offence for the recovery of a legal order that has been seriously shaken by the offence, and the effects of the death of the hunger striker on society". Whether these statements by Minister Donner meant a radical change in policy, or were mainly inspired by political pressure and social turmoil remains unclear. In the 2006 case of Šešelj, the Dutch government again showed willingness to apply force-feeding to this prisoner on hunger strike, but in my opinion this can be explained by the strong Dutch sense of commitment towards this Tribunal, and the commitment to execute their order.

Physicians cannot be compelled to apply force-feeding, as they are guided by their own medical standards. This was also acknowledged by Minister Donner during the hunger strike of Volkert van der G. During this strike, Dutch national medical associations strongly opposed force-feeding competent prisoners on hunger strike, and strongly advised against the participation of physicians in force-feeding practices. From a letter of the Dutch Health Care Inspectorate it can be concluded that physicians would even face disciplinary proceedings before the Central Medical Disciplinary Tribunal if they participated in force-feeding competent hunger strikers. Nevertheless, several physicians declared that they would force-feed Volkert van der G. If asked to do so. As these physicians were also Members of Parliament for the Pim Fortuyn list, however, it can be seriously doubted whether this willingness was inspired by medical-ethical considerations or by political motives.

The struggle between Minister Donner and the national medical associations is, in my opinion, strongly reflected in the case of CDA politician and physician Siem Buijs, who has stated that he, as a politician in favour of force-feeding, would cooperate in force-feeding practices, but as a physician he would not. The same goes for physician Van der Heide, who declared, although working as medical advisor on the Ministry of Justice under Minister Donner, that he would refuse to participate in force-feeding a competent hunger striker if asked.[55] In 2002, Minister Donner announced that a new circular would be published in which clarity would be provided on the new broader assessment framework of Article 32 PPA, and in this way also provide more clarity on the legitimacy of force-feeding prisoners on hunger strike. This new circular has not yet appeared, and so the current Dutch policy on the force-feeding prisoners

[55] KNMG 2002-II.

on hunger strike remains unclear. Yet, with the failure of the new circular to appear, the 1985 circular, that places emphasis on the will of the hunger striking prisoner and shows respect for his right to self-determination, is still in effect.[56] As a result, prisoners can still invoke this circular in legal proceedings.

It can be concluded that throughout the years, Dutch policy has consistently attached much value to prisoners' and detainees' decision to go on hunger strike, and has rejected force-feeding in hunger strikes. Still, the case of Volkert van der G. showed that in a hunger strike with a high political profile, this policy can be severely challenged.

3. GERMANY

3.1. INTRODUCTION

In the 1970s and 1980s, hunger strikes among prisoners were a common phenomenon in Germany. Members of the Red Army Faction (*Rote Armee Fraktion*, hereafter: RAF) gained a lot of publicity by using hunger strikes as a means to reinforce their political resistance. In this period, the force-feeding of hunger strikers was the topic of heated debate, as reflected in the number of reflective and in-depth publications (of mostly legal scholars) on this topic during this period.[57] Current policy on force-feeding hunger strikers in Germany is strongly influenced by the turbulent experiences with these political hunger strikes in the past. The RAF hunger strikes led to the creation of Section 101 of the Enforcement of Punishments Act (*Strafvollzug*) that governs coercive medical measures in prison and strongly influenced its amendment in 1985.

Below, I will go into the German legal framework for the assessment of force-feeding, focusing on the creation and development of Section 101 of the Enforcement of Punishments Act. First of all, I will sketch the events that led to the creation of this section in 1976. After this, I will go into the debate that this Section has invoked after its creation, the experiences with the RAF hunger strikers at the beginning of the 1980s and the legislative change in Section 101 in 1985. I will go into the current dilemmas surrounding the issue of hunger strikes, and the creation of stipulations concerning coercive medical treatment on a state level as a result of the reform of federalism. Finally, I will offer conclusions on the German policy on force-feeding prisoners on hunger strike.

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[56] The Circular is, according to its text, not limited in time. The Council for the Administration of Criminal Justice and Youth Protection has furthermore determined that circulars that have no limited period of validity remain in effect unless they have been withdrawn. Beroepscommissie RSJ d.d. 23 December, No. A 96/514, discussed in *Sancties* 1997, 37.

[57] See, amongst many others, Winiger 1978, Geppert 1976, Eschen 1981, Geppert 1983, Wagner 1976 and Nöldeke & Weichbrodt 1981.

3.1. LEGAL FRAMEWORK

First of all, when considering Enforcement of Punishments Acts in Germany, it is important to denote the difference between the federal and state levels. In 1990, the (Western) Federal Republic of Germany was reunited with the (Eastern) Democratic Republic of Germany. Since then, Germany has a federal constitutional structure with 16 federal states (*Länder*) and a federal level. Within the traditional categories of comparative law, Germany belongs to the circle of civil law countries, like the Netherlands. I will first investigate the legal framework relevant for the assessment of force-feeding prisoners on hunger strike that is constituted by the German Basic Law and the more specific laws that govern the position of prisoners.

In the hierarchy of norms, the German Basic Law (*Grundgesetz*) is the supreme law of the land, followed by Federal Statutes and state legislation. The ECHR has been transformed into a Federal Statute, and the German Federal Constitutional Court (*Bundesverfassungsgericht*) has ruled that German courts and agencies are constitutionally required to interpret domestic German law in accordance with Germany's obligations under international law, including the ECHR, if this does not run contrary to constitutional principles. The basis for prisoner's rights and duties can be found in the federal Enforcement of Punishments Act, which came into force on 1 March 1976 as the first ever Enforcement of Punishments Act in West Germany and became binding law in all Germany after the German unification in 1990. This Enforcement of Punishments Act provided a statutory framework, while the task of implementing the law resided with the federal states.[58] In 2006, however, a reform of federalism changed this situation.

From this moment on, the execution of all forms of detention became the competence of the federal states. Nowadays, several states are preparing their own new Enforcement of Punishments Acts, while others have already established new ones. Some states have seized this opportunity to establish for the first time a specific statutory basis for the execution of juvenile sentences or pre-trial detention.[59] At the time of writing (February 2012), five states have created their own Enforcement of Punishments Acts. In the eleven states that have not yet created their own Acts, the federal Enforcement of Punishments Act is still applicable. As this federal Enforcement of Punishments Act is still applied in the majority of the federal states, in this chapter I will first investigate how the issue of force-feeding prisoners on hunger strike is arranged on a federal level. After this, I will discuss the states' Enforcement of Punishments Acts, and investigate the similarities and differences between the states' newly created Enforcement of Punishments Act and the federal Enforcement

58 Dünkel & Rössner 2001, pp. 288 and 302.

59 National report Germany by Marianne Kunisch, p. 1. <http://www.aeud.org/file/munich2007/Kunisch_report-germany.pdf> (last accessed on 3 February 2012).

of Punishments Act as still applied in the eleven states that have not yet created their own Acts. I will also do so for the stipulations concerning pre-trial detention.

The prisoner's legal status and the Enforcement of Punishments Act in general, are underpinned by the rights and principles of the 1949 German Basic Law. The Basic Law forms the heart of German legal culture: the fundamental rights as laid down in the Basic Law occupy a central place in the German legal order.[60] Created in 1949, the German Basic Law was based on the principle of inviolability of human dignity. This principle was prominently laid down in Article 1 of the Basic Law. Articles 1 and 2 of the Basic Law concern human dignity and personal freedoms, including the right to free development of personality and the right to life and physical integrity. Article 1, the most important in the German Basic law, states that

> 1. Human dignity shall be inviolable. To respect and protect it shall be the duty of all state authority.
>
> 2. The German people therefore acknowledge inviolable and inalienable human rights as the basis of every community, of peace and of justice in the world.
>
> 3. The following basic rights shall bind the legislature, the executive, and the judiciary as directly applicable law.[61]

Article 2 states that

> 1. Every person shall have the right to free development of his personality insofar as he does not violate the rights of others or offend against the constitutional order or the moral law.
>
> 2. Every person shall have the right to life and physical integrity. Freedom of the person shall be inviolable. These rights may be interfered with only pursuant to a law.[62]

Articles 1 and 2 are the most general of the Basic Rights. It can be said that the libertarian interests recognised in Article 2 are corollaries of the principle enunciated in Article 1. These two Articles are always read in tandem, they are "symbiotic".[63] Although because of the 2006 reform of federalism, Enforcement of Punishments Acts may differ between states, the Federal Constitutional Court can be called upon to assess their conformity with the fundamental rights as laid down in the Basic Law, such as human dignity. Furthermore, for prisoners, Article 104 of the Basic Law is important, as this stipulates that persons in custody may not be subjected

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60 Lazarus 2004, pp. 23-24.

61 Translation by <http://www.iuscomp.org/gla/statutes/GG.htm> (last accessed on 3 February 2012).

62 Ibid.

63 Pagán 1998, p. 349.

to mental or physical mistreatment. In this, some authors recognise a codification of the respect for human dignity.[64] The rights as laid down in the Basic Law not only apply in the relationship between the State and its citizens, but are universally binding and are directly enforceable law. According to Article 1, paragraph 3, all public bodies must promote and protect the rights and principles enshrined in the German Basic Law.

In Germany, no concrete judicial stipulations concerning consent for medical interventions exist. Medical interventions are considered to contain the elements of criminal offence under Section 223 of the German Criminal Code (*Strafgesetzbuch, StGB*) i.e. causing bodily harm (*Körperverletzung*). The main position of the German courts and the literature is that any invasion into the body of a person fulfils the crime of causing bodily harm in the sense of Section 223 of the Criminal Code and is unlawful, unless it is justified, as in particular by informed consent by the patient, or, as in the case of prisoners, by special justification, such as according to Section 101 of the Enforcement of Punishments Act. If such a justification is present, this negates the unlawfulness of the act.[65]

The requirement of consent is founded in respect for the patient's physical integrity and his right to self-determination. The right to self-determination and the right to refuse medical treatment are explicitly acknowledged by the Federal Constitutional Court. This Court has ruled that the right to self-determination can be derived from Article 2, paragraph 1, of the Basic Law; the right to free development of his personality. It has also acknowledged that from the right to free development of personality a right to refuse medical treatment can also be derived.[66] According to case law, medical treatment performed without valid consent of the patient is considered as a violation of the patient's physical integrity, but also as a violation of the patient's right to self-determination.[67]

As with the patient's consent, medical intervention can be legally justified by an emergency situation as defined in Section 34 of the Criminal Code or the patient's presumed consent. The latter comes into consideration when the patient's explicit or implicit consent cannot be obtained in time before the intervention, such as if the patient is unconscious. The patient's presumed wishes are primarily determined from the patient's known personal interests, desires, needs and values. The patient can only give valid consent to his medical treatment after he has been informed of the material circumstances, modalities and risks of the impending medical intervention.[68] The requirements for informed consent in German law are principally developed in

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64 Laue 2005, p. 220, with references.

65 This construction of "*Heilbehandlung*" is very much disputed, see, for example, Eser 1994 and the commentary on Section 223, under 27, of the Criminal Code in Schönke & Schröder 2010.

66 BVerfGE 52, 131, 170 and BVerfGE 32, 98, 110.

67 See, *inter alia,* BGH NStZ 1996, 34 and BGHSt 11, 11, 114.

68 Parzeller et al. 2007, pp. 576-577.

case law. Insofar as a statutory regulation exists, it only regulates special cases, such as informed consent for drug testing or castration, and it presumes the existence of an informed consent requirement rather than establish it.[69] The medical profession, conversely, is very clear on this point, stating in their Professional Code under *Behandlungsgrundsätze und Verhaltensregeln*, that "any medical treatment has to be performed with respect for human dignity and respect for personality, the rights and the will of patients, in particular the right to self-determination" (Section 7, paragraph 1).[70] Accordingly, the physician must adequately inform his patient and obtain consent before he can administer medical treatment. If the patient refuses, there is no legal obligation for the physician to carry out the medical intervention, even if there is no obvious reason for the patient to refuse the medical intervention. The patient's wishes are, ultimately, decisive.

For minors under the age of 14, consent should be obtained from legally authorised guardians, usually parents. Such consent can only be given by both parents jointly.[71] The only exception to this principle is when the intervention is not of a high degree of difficulty. If the patient's parents refuse the intervention and time is of the essence, a medical intervention for the protection of the minor may be justified under Section 34 (justifying necessity, *Rechtfertigender Notstand*) of the Criminal Code. If this is not the case, a decision in favour of the intervention must be obtained from the family court (*Familiengericht*).[72] A part of this family court is the *Betreuungsgericht*, which is concerned with cases which concern people who are deprived of their liberty, such as guardianship procedures.[73] Minors from between 14 and 18 can give legally valid consent if the physician, taking the nature and seriousness of the proposed intervention into account, concludes that the patient possesses the necessary capacities of understanding and judgment to make a well-reasoned decision. The minor patient's ability to consent must be assessed in the light of the concrete circumstances of the individual case.[74]

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69 Eser 1994, p. 238.

70 "*Jede medizinische Behandlung hat unter Wahrung der Menschenwürde und unter Achtung der Persönlichkeit, des Willens und der Rechte der Patientinnen und Patienten, insbesondere des Selbstbestimmungsrechts, zu erfolgen*." (Muster-) Berufsordnung für die deutschen Ärztinnen und Ärzte (2006). Accessible at <http://www.bundesaerztekammer.de/page.asp?his=1.100.1143> (last accessed on 3 February 2012).

71 Legal representatives of minors are as a rule their parents who in principle hold joint custody, see Articles 1626 and 1629 of the Civil Code. In the case of single custody, only the parent who is granted custody is required to consent.

72 Until 2009, these cases were dealt by with the Vormundschaftsgericht. This changed with the entry into force on 1 September 2009 of the "Gesetz über das Verfahren in Familiensachen und in den Angelegenheiten der freiwilligen Gerichtsbarkeit (FamFG)", d.d. 17 December 2008, Bundesgesetzblatt I p. 2586.

73 Cf paragraph 23, under c), *Gerichtsverfassungsgesetz*.

74 Parzeller et al. 2007, p. 582.

In the case of an adult who suffers from a mental illness, on the basis of Section 1896 ff of the German Civil Code, a custodian can be appointed by the custodianship court to decide for him, also in medical cases. Section 1906 of the Civil Code governs the placement of an adult by a custodian that involves deprivation of liberty, as well as placement for the administration of necessary medical treatment. According to this Section, it is admissible for the custodian to put the person under custodianship in accommodation that is associated with deprivation of liberty only as long as this is in the best interests of the person under custodianship 1) by reason of a mental illness or mental or psychological handicap of the person under custodianship if there is a danger that he will kill himself or cause substantial damage to his own health, or 2) if an examination of the state of health of the person under custodianship, therapeutic treatment or an operation is necessary without which the person under custodianship cannot be placed in the accommodation and the person under custodianship, by reason of a mental illness or mental or psychological handicap, cannot recognise the necessity for the accommodation or cannot act in accordance with this realisation.

Such placement is only admissible with the approval of the custodianship court. Without the approval, the person under custodianship can only be placed in the accommodation if a delay would entail risk; the approval must thereafter be obtained without undue delay (paragraph 2). Private law placements are intended to serve the health interests of the individual and are regulated by federal civil law. No criteria for involuntary treatment are defined in the Civil Code. Still, the Federal Supreme Court (*Bundesgerichthof*) has determined that administering coercive medical treatment requires the consent of the custodian.[75] In the case of medical measures, the consent of the custodian to an examination of the state of health of the person under custodianship, to therapeutic treatment or to an operation is also subject to the approval of the custodianship court if a justified danger exists that the person under custodianship will die or will suffer serious injury to his health that lasts for a long period by reason of the measure. Without this approval, the measure may be carried out only if delay would entail danger (Section 1904). This is different if the patient has drawn up a living will. In the case of a living will by the person involved in the event of his becoming unable to consent, the custodian must examine whether these determinations correspond to the current living and treatment situation. If this is the case, the custodian must see to it that the will of the person under custodianship is carried out (Section 1901a). If there is no living will, or the determinations of a living will do not correspond to the current life and treatment situation, the custodian must determine the wishes with regard to treatment or the presumed will of the person under custodianship, and decide on this basis whether he consents to or prohibits the medical measure. The presumed will must be ascertained on the basis of concrete indications. Consideration must be given, in particular, to previous oral or written statements, ethical or religious

[75] BGH XII ZB 236/05.

convictions and other personal values of the person under custodianship (Section 1901a, second paragraph).

Besides placement under private law (as stated above, i.e. placements intended to serve the health interests of the individual) there is also placement under public law. This is intended to avert danger to oneself and to third parties. For this, the criteria for the placement of the mentally ill are defined by the law of each federal state. It would fall outside the scope of this research to go into all these laws. Here, I suffice to mention that all these state laws contain stipulations for involuntary treatment, and require the consent of the patient, and – when incapable of consent – his legal representative, for medical procedures.

The seventh title, Sections 56-66, of the Enforcement of Punishments Act concerns medical services in prison. On the basis of Section 56 of the Enforcement of Punishments Act, care shall be taken over the prisoner's physical and mental health. In this Section it is explicitly mentioned that Section 101 shall remain unaffected. The second paragraph adds that the prisoner must support all measures necessary for the protection of health and hygiene. Section 58 furthermore determines that prisoners shall be entitled to therapeutic treatment provided that it is necessary to diagnose or cure a disease, prevent it from deteriorating or alleviate its symptoms. Medical care shall be ensured by medical officers employed on a full-time basis (Section 158).

Prisoners have no codified right to consent before medical intervention can take place. The only medical treatment that requires the prisoner's consent, according to Section 63 of the Enforcement of Punishments Act, is "in particular operations or prosthetic measures which promote his social integration".[76] As a basic rule, Section 4 of the Enforcement of Punishments Act stipulates that "the prisoner shall be subject to such restrictions of his liberty as are laid down in this Act. Unless the Act provides for a special regulation, only such restrictions may be imposed on him as are indispensable to maintain security or to avert serious disturbance of order in the penal institution." One such restriction is formulated in Section 196 of the Enforcement of Punishments Act. This Section determines that the basic constitutional rights of prisoners under Article 2 of the Basic Law, first and second sentence, the right to physical integrity and freedom of the person can be restricted. This is the case for coercive medical treatment in prisoners on the basis of Section 101 of the Enforcement of Punishments Act, as will be shown below. Section 101 governs forced measures in the field of medical care for a wide range of situations, such as infectious diseases, the risk of suicide or self-harm or aggression as a result of a mental disorder.[77] As the stipulation itself mentions, this Section also governs

[76] All translations of the current Enforcement of Punishments Act are by the Centre for German Legal Information: <http://www.cgerli.org/fileadmin/user_upload/interne_Dokumente/Legislation/Prison_Act.pdf> (last accessed on 3 February 2012).

[77] Laue 2005, p. 217, with references.

force-feeding in prisoners on hunger strike, which includes the application of force-feeding. As will be shown in § 3.4 of this chapter, in fact, Section 101 has been mostly discussed in relation to force-feeding prisoners on hunger strike, and it was even incorporated in the law for exactly this purpose.

According to Section 1, the Enforcement of Punishments Act regulates "the execution of sentences of imprisonment in penal institutions and of measures of rehabilitation and prevention involving deprivation of liberty". Pre-trial detention is governed on the federal level by the *Untersuchungshaftvollzugsordnung*.[78] This document determines under 72 (under 1), that for the use of immediate force the statutory provisions apply ("*Für die Anwendung unmittelbaren Zwangs gelten die gesetzlichen Vorschriften*"). According to Section 178 of the Enforcement of Punishments Act, the stipulations concerning direct coercion (Sections 94 to 101 of the Act) also apply to "prison officers outside the scope of application of the Enforcement of Punishments Act". Accordingly, Section 101 of the Act concerning force-feeding is also applicable in the execution of, *inter alia*, pre-trial detention. Since the 2006 reform of federalism in February 2012, fourteen states have created their own Codes of Pre-trial Procedure (*Untersuchungshaftvollzugsgesetz*), while Bavaria and Schleswig-Holstein are still in the process of creating such a code. In these codes, all states have incorporated stipulations that are similar to that of Section 101 of the Enforcement of Punishments Act. I will investigate these new Codes of Pre-trial Procedure in § 3.9 of this chapter.

3.3. THE RAF HUNGER STRIKES AND THE DEATH OF HOLGER MEINS

The discussion of the legitimacy of coercive medical measures, including that of force-feeding of prisoners on hunger strike in Germany goes back a long way, but was of little significance for a long time. Apart from attention for the hunger strikes of imprisoned suffragettes in the UK (see § 4.4 of this chapter) and Communist prisoners in Germany after 1918, not much attention was paid to this issue.[79] This rapidly changed with the collective, simultaneous and long-term hunger strikes by RAF prisoners in the 1970s and 1980s.

Holger Meins, born on 26 October 1941 in Hamburg, was one of the key figures of the RAF (also referred to as the Baader-Meinhof group). For many years, the RAF strongly disrupted German society with their terrorist activities. Nowadays,

[78] Morgenstern notes that "*Untersuchungshaft*" in German law is the deprivation of liberty of an untried or not yet finally convicted person. "*Untersuchungshaft*", for this reason, comprises a longer period than only the pre-trial phase, since it also comprises the period of detention during an appeals procedure. Morgenstern 2009, p. 407.

[79] Laufs & Uhlenbruck 2002, § 153, Rn 6-8.

the RAF is considered the most active leftwing terrorist group in post-war Germany. The RAF was founded in 1970 by Gudrun Ensslin, Horst Mahler, Andreas Baader and Ulrike Meinhof (the so-called first generation). For a little over two years, the group existed underground, robbing banks and carrying out bombings, before the leaders were arrested in June 1972. After the arrest of these leaders the RAF campaign continued from prison. Central to this prison protest was the practice of hunger strike. These hunger strikes, together with accompanying texts and statements, constituted an important part of an effective media campaign. Passmore qualifies the RAF hunger strikes as being part of their strategy "to counter a medicalization of terrorism", which "allowed RAF prisoners literally to *embody* their established rhetoric of 'anti-fascism' and 'anti-imperialism'".[80] This strategy was not without result. According to Passmore, "[t]he approximately five-year incarceration of the first generation proved a far more effective period in terms of self-promotion and public response than the two years underground".[81]

In 1972, a first hunger strike was undertaken by Andreas Baader, during the trial of Horst Mahler. This was the first of a long line of major public hunger strikes, undertaken by members of the RAF (and in their wake followed by sympathisers) in German prisons. Many of the first generation RAF members were sentenced to life imprisonment for terrorist activities, and were placed under strict prison regimes. Many of them went on a hunger strike, *inter alia*, in protest against their oppressive prison regimes and conditions. In most cases, they were fiercely determined to reach their goals and were prepared to die in order to achieve them.[82] It was during the second major hunger strike by eighty prisoners in May-June 1973 that force-feeding of hunger strikers was used for the first time. Several German prisons were confronted with prolonged hunger strikes by RAF members, many of them severely malnourished. In prisons in, *inter alia*, North Rhine-Westphalia and Rhineland-Palatinate prisoners on hunger strike were force-fed.[83]

Usually, the RAF hunger strikes were very well-planned; in July 1973 a manual for hunger strike was found in the cell of Ulrike Meinhof that described in great detail the course of a hunger strike and its physical consequences. This allowed the hunger strikers to anticipate on the dramatic physical consequences of their actions. Although some hunger strikes endured for a long period and some of the hunger striking prisoners became very ill as a result of their actions, it was not until the

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80 Ibid., p. 33.

81 Passmore 2009, p. 34.

82 As Winiger stated: "*Dass […] die Mitglieder der Baader-Meinhof-Gruppe bei ihren Hungerstreiks mit dem Tod rechneten, dürfte ohne Zweifel sein.*" (It can be stated without doubt that the members of the Baader-Meinhof group with their hunger strikes counted into their deaths). Winiger 1978 pp. 388-389.

83 "Wir oder sie auf Leben und Tod" (Us or them, a life and death fight), *Der Spiegel,* Vol. 36, d.d. 29 August 1977, p. 31.

third and longest hunger strike (of 145 days) that fatalities occurred. This was the hunger strike that was started in September 1974 by Ulrike Meinhof. Holger Meins was one of the participants in this hunger strike. Although being force-fed several times (for the first time after 14 days), he died on 9 November 1974 in Wittlich prison in Rhineland-Palatinate after 56 days of hunger striking, protesting against his solitary confinement. When he died, Holger Meins weighed no more than 39 kg with a height of approximately 1.86 meters. Pictures of his emaciated body appeared in media around the world. His death gave rise to protests and riots across Europe and strongly divided the West German population between sympathisers with the RAF's actions (who qualified Holger Meins' death as murder) and those who opposed to the RAF's violent actions. Although it was not the last hunger strike by RAF members in prison, it was this hunger strike in particular and the subsequent death that became the topic of a heated public and political debate that led the discussion of force-feeding prisoners on hunger strike to its first climax.

3.4. SECTION 101 OF THE ENFORCEMENT OF PUNISHMENTS ACT AND FORCE-FEEDING PRISONERS ON HUNGER STRIKE: CREATION AND DEVELOPMENT

In 1975, Section 101 of the Enforcement of Punishments Act, which governs coercive measures in the field of medical care, was drafted. However, according to Passmore, this was only a "hurried compromise", that allowed for neither absolute rights for prisoners nor unreserved obligations on prison doctors.[84] Practice showed that this hasty political compromise was hardly useful. With the coming into force of the Enforcement of Punishments Act in 1976, a new Section 101 was introduced in an attempt to settle the issue of force-feeding prisoners on hunger strike.

After the RAF hunger strikes and the death of Holger Meins, it was Professor Carstens, chairman of the CDU/CSU-*Bundestag* parliamentary party who in particular put the issue on the political agenda. This led to a lively discussion, not only in politics, but also within the medical profession and churches.[85] Public opinion seemed in favour of abstaining from force-feeding prisoners on hunger strike. The results of a representative survey amongst German citizens in *Die Zeit* showed that 74 per cent of the respondents answered no to the question of whether terrorist prisoners on hunger strike must be force-fed.[86] Also, physicians expressed their

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84 Passmore 2009, p. 36.

85 Wagner 1976, p. 1.

86 "Wir oder sie auf Leben und Tod" (Us or them, a life and death fight), *Der Spiegel,* Vol. 36, d.d. 29 August 1977, p. 31. Yet, it remains unclear in my opinion, if this outcome was caused by the aversion to force-feeding practices by the general public or was based on hostility towards the RAF prisoners then on hunger strike and a feeling not to be appalled by the prospect of their imminent death.

resistance to force-feeding. On 7 December 1974, the (Federal) German Medical Association (*Bundesärztekammer*, the umbrella organisation in which the 17 German state medical associations are united), during its annual general meeting spoke out against force-feeding of competent (*freiverantwortlichen*) hunger strikers.[87]

Still, the final question of the legitimacy of force-feeding was settled in the political arena. For the creation of the new Section 101 of the Enforcement of Punishments Act a special committee for criminal law reform (*Der Sonderausschuß für die Strafrechtsreform*) addressed the issue of force-feeding in great detail. Geppert, Wagner and Laue have described this process, and have outlined the views in this committee that for a long time were in conflict. According to them, some, mostly members of the CDU/CSU, emphasised the medical nature of the application of feeding, a medical procedure that in principle requires the patient's consent, and argued in favour of a view parallel to the situation of medical treatment of persons at liberty, in which the fundamental right to self-determination and physical integrity in competent patients prevailed. Together with the extensive use of force involved in force-feeding, and the medical risks of such an intervention, they principally rejected force-feeding. Accordingly, they wanted to make the application of feeding and treatment of hunger striker dependant on the will of the prisoner; a policy that could, in the final analysis, result in the hunger striker's death. According to Geppert, Wagner and Laue, the members of the SPD/FPD took another approach to the issue. Besides the State's duty to care, the SPD/FDP members also took policy, political and security considerations into account when arguing in favour of a duty for the State to force-feed prisoners on hunger strike. Although the members of the SPD/FPD acknowledged the parallel between medical intervention in hunger strikes and medical intervention with persons who are at liberty, they stated that if the authorities were not under an obligation to force-feed the hunger striker from the beginning, they would be faced with the difficult task of determining whether, if so how, and when the force-feeding should be applied. With this, the prison authorities would be forced into the role of "executioner" (*eine Henkerrolle)* "for which they could neither practically nor morally be held responsible". Also, they emphasised the fact that hunger strikes can severely disturb the internal order in the prison. In addition, they stated that prisons would become hospices (*Sterbekliniks*) if hunger strikers were not kept alive by means of force-feeding. Furthermore, the principle of humanity also required intervention when a person of sound mind exposes himself to the risk of death by his actions. Because of all this, members of the SPD/FPD, supported by representatives of the Federal Ministry of Justice, pleaded in favour of an absolute duty to force-feed.[88]

In the literature, the position of the SPD/FDP has been regarded as an attempt to protect State authority against negative public opinion caused by the hunger

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87 *Deutsches Ärzteblatt* 1974, p. 3661.

88 Geppert 1976, pp. 43-44, Wagner 1976, p. 2 and Laue 2005, p. 225.

striker's action, and to protect it against hunger strikers who disavow criminal proceedings and discredit the prison system with their actions.[89] After the (then) CDU states North Rhine-Westphalia and Rhineland-Palatinate (who were already applying force-feeding in hunger striking prisoners, see § 3.3 of this chapter) took similar positions as the majority in the *Bundestag*, the CDU/CSU parliamentary party dropped their opposition and a compromise was reached, resulting in the creation of Section 101 of the Enforcement of Punishments Act.[90]

This new 1976 Section 101 described the State's duty to force-feed prisoners on hunger strike and its limitations. It read as follows

> 1) Medical examinations and treatment under coercion, as well as forced feeding, shall be permissible only in case of danger to life, in case of serious danger to the prisoner's health, or in case of danger to other persons' health; the measures must be reasonable and must not cause considerable danger to the life or health of the prisoner. The prison authority shall not be obliged to execute such measures as long as it can be assumed that the prisoner acts upon his own free will, unless there is immediate danger to life.[91]

The relevance of this Section to the issue of force-feeding was manifest: although force-feeding can be qualified as medical treatment under coercion, it was also explicitly mentioned in its first sentence. According to this first sentence, force-feeding (including the forced application of fluids) might be applied in the case of danger to life, or serious danger to the prisoner's health. Furthermore, the measures must be reasonable and must not cause considerable danger to the life or health of the prisoner. If these conditions are fulfilled, a right for the prison authorities to force-feed the prisoner on hunger strike exists. In such cases, the right to self-determination of the prisoner could be overruled by the State's duty to protect and preserve the prisoner's life and health. The second sentence of this section clarified when State authorities not only had the power, but were under an *obligation* to intervene. In this sentence, the prison authorities' obligation to execute forced medical treatment was formulated negatively: the prison authorities were *not* obliged to execute forced medical treatment as long as the prisoner was acting upon his own free will. It can be concluded that a duty to force-feed a prisoner on hunger strike only existed when the hunger striker was not acting upon his own free will. Accordingly, no duty to

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89 See, *inter alia,* Laue 2005, p. 225.

90 Geppert 1976, pp. 43-44, Wagner 1976, p. 2 and Laue 2005, p. 225.

91 "*Medizinische Untersuchung und Behandlung sowie Ernährung sind zwangsweise nur bei Lebensgefahr, bei schwerwiegender Gefahr für die Gesundheit des Gefangenen oder bei Gefahr für die Gesundheit anderer Personen zulässig; die Massnahmen müssen für die Beteiligten zumutbar und dürfen nicht mit erheblicher Gefahr für Leben oder Gesundheit des Gefangenen verbunden sein. Zur Durchführung des Massnahmen ist die Vollzugsbehörde nicht verpflichtet, solange von einer freien Willensbestimmung des Gefangenen ausgegangen werden kann, es sei den, es besteht acute Lebensgefahr.*"

force-feed a prisoner on hunger strike existed if the prisoner was acting upon his own free will. Nevertheless, under this section, under very specific conditions a duty – even when the prisoner was acting upon his own free will – to feed a prisoner on hunger strike by force was created. For this, immediate danger to the hunger striker's life was required. In such case, the prisoner's free will could not remove the State's duty to force-feed in case of immediate danger.

This new Section on force-feeding was meant to clarify the relationship between the prisoners' individual rights on the one hand, and the rights and duties of the State to intervene in the prisoner's hunger strike on the other hand. Under this Section, the prisoner's will and decision to hunger strike could be overruled by the State's duty to intervene. This was mainly prompted by the idea of reducing the hunger striker's room to negotiate and to prevent him from blackmailing the State by his actions. By clarifying the expected response, the hunger striker could know that he would be force-fed if his situation became critical: often politically the most "effective" period for the hunger striker to negotiate his demands. Since hunger strikers could no longer reckon with their health being artificially maintained, this would nullify their strategy.[92]

The new Section 101 was a compromise between the wishes of the SPD/FDP for an absolute duty to force-feed, and the wishes of the CDU/CSU to regard force-feeding as a medical intervention. The political compromise was severely criticised in the legal literature, among others by Wagner, who described the new Section 101 – which contains neither an absolute right to hunger strike nor an absolute right to intervention – as "a classic example of how political constraints prevent adequate legal and workable solutions" and deemed the new Section 101 to be "a legal and political deplorable misconception".[93] In his view, that a prisoner is deprived of his liberty does not change the fact that he is entitled to the right to self-determination as laid down in the Basic Law, and that he, just like a patient in the free world, must consent before medical treatment can be performed. According to Wagner, the State's duty of care may not override the prisoner's right to self-determination, as the State's duty to care is only meant to compensate for the fact that the prisoner, whilst deprived of his liberty, cannot take care of his own health. Besides this, he noted that because of the concession to the CDU/CSU, force-feeding is regarded as a medical intervention. As a result, the duty to force-feed is dependent on medical indications that are not in line with medical and physiological/psychiatric aspects of the reality of hunger strikes. The fact that the hunger striker can be saved by force-feeding when he is in acute danger or when his free will is impaired, for example, is medically more than questionable. In his opinion, the only logical solution would be for the State to abstain from force-feeding hunger striking prisoners. Such an approach (as practised in England and Wales, see § 4 of this chapter), he argues, would take

92 Passmore 2009, p. 36.

93 Wagner 1976, pp. 1 and 3.

away some of the power of the hunger strike as a political weapon, as prisoners can no longer count on being kept alive in the critical phase of a hunger strike.[94] In this way, abstaining from intervention would nullify the strategy of hunger strikers, more than maintaining their health through force-feeding. Wagner did not stand alone in his opposition to force-feeding. Geppert, among many others, was also unfavourably disposed towards the force-feeding of hunger strikers. Geppert added to the criticism of Wagner that – apparently due to a lack of understanding about the duty to care (*offenbar aus fehlverstandener Fürsorgepflicht*, in his own words) the legislator in this new Section on force-feeding had made an unjustifiable difference between prisoners and persons in freedom regarding force-feeding, noting that in the latter group of hunger strikers force-feeding would not even be considered.[95]

As well as in the legal literature, within the medical profession the position towards the compromise of Section 101 Enforcement of Punishments Act was also critical. Physicians complained in particular of its lack of practicality,[96], as well as the many undefined legal terms.[97] For physicians, for example, the difference between the phrases "case of danger to life" as required in Section 101, paragraph 1, first sentence, and "immediate danger to life" as required for intervention against the prisoner's own free will in the second sentence of paragraph 1, was considered unclear and too vague, as the medical reality is that no unambiguous laboratory parameters exist to differentiate between them.[98] Moreover, they generally opposed force-feeding hunger strikers who act upon their own free will.[99] As stated above, in 1974, the German Medical Association spoke out against the force-feeding of competent hunger strikers.[100] This statement was reiterated during the German Medical Association's annual meeting, the German Medical Assembly (*Deutscher Ärztetag*) in Trier in 1981. In this statement, they emphasised the fact that a medical intervention may only take place when the patient consents to it (as also acknowledged by the German Federal Court, see § 3.2 of this chapter) and the medical risks of force-feeding.[101]

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94 Wagner 1976, pp. 3-4. Many German authors in discussing the legitimacy of force-feeding refer to the English solution (*Englischen Lösung)* of the hunger strike dilemma. Not only Wagner is of the opinion that this approach should be followed, this opinion is shared by Nöldeke & Weichbrodt 1981.

95 Geppert 1976, p. 45.

96 Geppert 1976, p. 45.

97 Laufs & Uhlenbruck 2002, § 153, Rn 6-8.

98 Puchstein & Lawin 1982.

99 Weichbrodt 1983, p. 311. References provided under footnote 3 there.

100 *Deutsches Ärzteblatt* 1974, p. 3661)

101 *Deutsches Ärzteblatt,* number 17, d.d. 23 April 1981 and *Berliner Morgenpost*, Vol. 119, d.d. 23 May 1981. Also Prof. Dissmann, Prof. Thimme and Dr Buschmann, all three working as internists and intensive care physicians in various medical hospitals in Berlin and involved in the three of six prisoners on hunger strike, stated in an interview in *Der Spiegel* that they considered force-feeding

Despite the resistance to force-feeding by the German Federal Medical Association, under the 1976 Section 101 of the Enforcement of Punishments Act physicians could be instructed by the prison authorities to apply force-feeding to prisoners who do not act upon their own free will, but in cases of immediate danger to life, also in prisoners who are acting upon their own free will.

Practice showed that not all physicians were willing to apply force-feeding in hunger strikers. On a state level, there was a strong difference in the willingness of physicians to execute force-feeding. For example, Section 1 of the professional code (*Berufsordnung*) for physicians in Berlin (a legally binding statute), codified the principle that the physician-patient is characterized by confidence.[102] In this provision, however, the exception to this rule is also laid down: if a legal obligation exists, the physician is not free to refuse to apply medical treatment, and he must obey this legal obligation. This is prompted by the notion that when a physician treats a patient against his will, and in this way interferes with the constitutionally protected sphere of freedom of human dignity and physical integrity, this requires an explicit legal basis.[103]

In Berlin, FDP Senator Justice Meyer had problems with prison physicians, in particular with the head of the department of internal medicine in Moabit prison hospital, Dr Leschorn, since all physicians refused to follow Meyers' instructions to perform forced medical treatment on hunger strikers for ethical and medical reasons. One of the physicians concerned, Dr Leschorn, tried to achieve better prison conditions in the high-security wing in order to end the hunger strike. As a result of his non-cooperative behaviour, he was relieved of his executive functions in the Moabit prison hospital, and transferred to a doctor's office in Tegel prison. In contrast to the attitude of the physicians in Moabit prison, in West Germany, prison physicians in Köln, Düsseldorf, Celle and Hamburg applied force-feeding, even at a relatively early stage of the hunger strike.[104]

Although force-feeding practices in prison remained controversial, from 1976 it was performed in West Germany. The 1976 political compromise that resulted in the new Section 101 did not turn out to be a solution to the problem of hunger strikes, since, although being threatened with force-feeding in prolonged hunger

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of prisoners who indicate that they refuse treatment and oppose to this treatment a violation of the prisoner's human dignity. "Hungerstreik – 'grünes Licht' für den Tod?" (Hunger strike – "green light" for death?), *Der Spiegel*, Vol. 16, 1981, p. 24.

102 "*Der Arzt ist verplichtet seinen Beruf Gewissenhaft auszuüben und sich bei seinem Verhalten der Archtung und des Vertrauens würdig zu zeigen, die der ärztliche Beruf erfordert. Der Arzt ist in der Ausübung seines Berufes grundsätzlich frei. Er kann eine ärztliche Behandlung, soweit er nicht rechtlich zu ihr verpflichtet ist, ablehnen, insbesondere dann, wenn er der Überzeugung ist, daß das notwendige Vertrauensverhältnis zwischen ihm und dem Kranken nicht besteht*." As cited by Eschen 1981, p. 81.

103 Eschen 1981, p. 81.

104 Becker 1981, p. 7.

strikes, it did not prevent massive hunger strikes by RAF members in prison from occurring. This was reflected in collective, simultaneous and long-term hunger strikes in the 1980s by prisoners, imprisoned because of terrorist activities, such as the 27 RAF members in 1981, who demanded a change in prison conditions, and the putting together of prisoners in groups.[105] During this hunger strike, prisoners were force-fed. Sigurd Debus was one of the participants in this strike. During the application of force-feeding, he lost consciousness and died on 16 April 1981 in Hamburg. This hunger strike and the subsequent death of Debus led the discussion to the question of force-feeding to a second climax.

This again resulted in legislative reform. Although the EComHR in 1984 upheld the obligation to intervene in case of an obvious threat to the hunger striker's life under German Law in *X v Germany* – by holding that a decision to force-feed a prisoner on hunger strike with a view to securing his survival was acceptable in case of such a threat to the prisoner's life[106] – the legislator amended Section 101 of the Enforcement of Punishments Act in 1985. During this legislative reform, the last part of the last sentence of the section, "unless there is immediate danger to life", was removed.[107] Although this seems a minor change, this deletion had major consequences, as it removed the State's duty to undertake forced medical intervention against the prisoner's wishes when immediate danger to life exists. With this, the legislator attempted to provide more clarity and certainty in the practical handling of hunger strikers.

This new approach was reflected in the last collective hunger strike by RAF prisoners in 1989. In this hunger strike, force-feeding was no longer applied, due to the 1985 legislative amendment. Instead of applying force-feeding at an early stage of the hunger strike, the hunger strikers were only medically observed. Physicians only intervened on the basis of Section 101 in prisoners with changing and unclear mental status and permanent damage to organs such as the heart and kidney.[108] Although the provision on the duty to intervene when acute danger to life existed had been deleted, the prisoners did not count on a change in prison policy. The new waiting response of the prison to their actions made it difficult for the hunger strikers to mobilise supporters and family members. Since the prisoners did not

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105 "Hungerstreik – 'grünes Licht' für den Tod?" (Hunger strike – "green light" for death?), *Der Spiegel,* Vol. 16, 1981, p. 24.

106 The EComHR noted in this respect that it was "satisfied that the authorities acted solely in the best interests of the applicant when choosing between either respect for the applicant's will not to accept nourishment of any kind and thereby incur the risk that he might be subject to lasting injuries or even die, or to take action with a view to securing his survival although such action might infringe the applicant's human dignity." EComHR 9 May 1984, *X v Germany*, App. No. 10565/83, 7 E.H.R.R. 135, p. 154. See for an elaboration on this case Ch. 5, § 3.4.3.

107 StVollzÄG 27 February 1985, BGBl. 1985 I, p. 461.

108 Schwind, Böhm & Jehle 2005, pp. 721-722.

wish to die, they could no longer rely on their health being artificially maintained by the authorities and the hunger strike was curtailed and finally aborted.[109]

To date, the first paragraph of Section 101 has remained unchanged.

3.5. THE CURRENT SECTION 101 OF THE ENFORCEMENT OF PUNISHMENTS ACT AND FORCE-FEEDING PRISONERS ON HUNGER STRIKE

The current Section 101 on coercive measures in the field of medical care is embedded in the twelfth title of the Enforcement of Punishments Act that governs direct coercion (Articles 94-101) and reads as follows

> (1) Medical examinations and treatment under coercion, as well as forced feeding, shall be permissible only in case of danger to life, in case of serious danger to the prisoner's health, or in case of danger to other persons' health; such measures must be reasonable for the persons concerned and may not entail a serious danger to the prisoner's life or health. The prison authority shall not be obliged to execute such measures as long as it can be assumed that the prisoner acts upon his own free will.
>
> (2) For the purpose of health protection and hygiene, a coercive physical examination shall be permissible in addition to that in subsection (1) if it does not involve an operation.
>
> (3) The measures shall be carried out only upon orders from, and under the supervision of a medical officer, except where first aid is rendered in case a medical officer cannot be reached in time and any delay would mean danger to the prisoner's life.[110]

Uniform federal regulations (*Bundeseinheitliche Verwaltungsvorschriften*), together with this Section, describe important aspects that must be arranged in each individual

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109 Schwind, Böhm & Jehle 2005, p. 716.

110 "*(1) Medizinische Untersuchung und Behandlung sowie Ernährung sind zwangsweise nur bei Lebensgefahr, bei schwerwiegender Gefahr für die Gesundheit des Gefangenen oder bei Gefahr für die Gesundheit anderer Personen zulässig; die Maßnahmen müssen für die Beteiligten zumutbar und dürfen nicht mit erheblicher Gefahr für Leben oder Gesundheit des Gefangenen verbunden sein. Zur Durchführung der Maßnahmen ist die Vollzugsbehörde nicht verpflichtet, solange von einer freien Willensbestimmung des Gefangenen ausgegangen werden kann.*

(2) Zum Gesundheitsschutz und zur Hygiene ist die zwangsweise körperliche Untersuchung außer im Falle des Absatzes 1 zulässig, wenn sie nicht mit einem körperlichen Eingriff verbunden ist.

(3) Die Maßnahmen dürfen nur auf Anordnung und unter Leitung eines Arztes durchgeführt werden, unbeschadet der Leistung erster Hilfe für den Fall, daß ein Arzt nicht rechtzeitig erreichbar und mit einem Aufschub Lebensgefahr verbunden ist."

case of a hunger strike.[111] First, it determines that statements by prisoners, which can be relevant to forced medical intervention, such as force-feeding, must be recorded in writing and signed by the prisoner involved. If the prisoner refuses to sign his statement, this must also be recorded. Oral statements made in the presence of witnesses must be recorded in writing and signed by the person involved or the witness. The written statement or record of the oral statement must be included in the medical records and personal files of the prisoner. Secondly, they require the prison physician to inform the prisoner in the presence of a witness of the need of medical intervention. Also, the possibility of forced medical treatment and the health consequences of non-treatment must be explained to the prisoner. This instruction is to be recorded. Thirdly and finally, they determine that a prisoner who persistently refuses to take food is observed medically.

According to the first sentence of the first paragraph of the current Section 101 of the Enforcement of Punishments Act, coercive measures in the field of medical care such as force-feeding may only be applied to prisoners when the prisoner's own health or life is seriously threatened or where the health of other prisoners is endangered in any way. The question of whether a danger to life or serious danger to the prisoner's health exists requires medical diagnosis. In this respect, it is acknowledged that a danger to life exists if there is a concrete and imminent danger that the prisoner will lose his life, and a serious threat to the prisoner's own health exists when important functions of the body in whole or in part are threatened with a permanent injury (minor injuries, although of a permanent nature, do not suffice).[112] The measures applied must have a therapeutic purpose; they must be intended to heal. Paragraph 1 of Section 101 of the Enforcement of Punishments Act governs coercive medical examination and treatment, including force-feeding, while paragraph 2 is applicable to physical examination that does not involve an operation, the so-called *nicht invasive Untersuchungen*, such as X-ray examination. In the literature, the legal basis for forced medical treatment as laid down in the current Section 101 is said to stem from the duty of care by the prison for the physical and mental health as formulated in Section 56 of the Enforcement of Punishments Act (first paragraph) and the duty for prisoners to support all measures necessary for the protection of health and hygiene (second paragraph).[113] If the prisoner consciously refuses to support the measures as mentioned in Section 56, second paragraph, the duty of the prison authorities to provide medical care can necessitate the use of force. In such cases, the prison authorities can oblige the prisoner to undergo medical interventions such as medical examinations, treatment

111 As described in, *inter alia,* Arloth 2005, p. 388.

112 Calliess & Müller-Dietz 2008, p. 487.

113 Kaiser & Schöch 2002, p. 354.

and force-feeding, also against his express or explicitly stated wishes, allowed under the general conditions as laid down in Section 101.[114]

According to the second sentence of the first paragraph of the current Section 101 of the Enforcement of Punishments Act, the prison authority is not obliged to execute coercive medical measures as long as it can be assumed that the prisoner is acting upon his own free will. Accordingly, a duty to intervene only exists in exceptional cases; i.e. when a hunger striker is not, or no longer, acting upon his own free will, for example when he suffers from a mental illness or when he is unconscious.[115] Although the prison authorities are no longer under a duty to intervene when immediate danger to life occurs to competent hunger strikers, on the basis of this section they still have the *right* (but not the duty) to apply forced coercive measures in the field of medical care against the prisoner's free will. In this way, the current Section 101 still offers far-reaching justification for force-feeding. On the basis of Section 95, force-feeding of non-cooperative prisoners can be accompanied by the use of physical force, or the use of shackles.

A right to intervene in a hunger strike on the basis of the first sentence of Section 101 through the use of force-feeding exists when 1) there is a danger to the prisoner's life or serious danger to the prisoner's health, 2) the measure is reasonable (*zumutbar*) for the person concerned, and 3) the measure applied does not entail a serious danger to the prisoner's life or health. These conditions are cumulative: the physician may not apply coercive medical treatment if any one of these elements is lacking.[116]

Calliess and Müller-Dietz state that the current Section 101 of the Enforcement of Punishments Act attempts to mediate between the absolute right of prisoners to self-control over their lives and the duty of care of the German welfare state to provide for its prisoners.[117] In the literature, other rights, fundamental (constitutional) values and interests are enumerated that also collide when the question of forced medical treatment arises. Besides the prison's duty of care as laid down in Section 56, Kaiser and Schöch also mention the prison's duty to prevent prisoners from committing suicide on the basis of Section 88, first sentence.[118] Furthermore, they mention the protection of State authority and law enforcement against discredit and

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114 Calliess & Müller-Dietz 2008, p. 483.

115 Although Section 101 mentions force-feeding, in case of unconsciousness of the hunger striker this should actually be referred to as "artificial feeding" since the hunger striker will not – or no longer – be able to resist, see Ch. 1, § 2.4. For readability purposes, however, in this part, I will refer to this kind of feeding as force-feeding, as this is the term as used in Section 101 of the Enforcement of Punishments Act.

116 Laufs & Uhlenbruck 2002, § 153, Rn 9-17.

117 Calliess & Müller-Dietz 2008, p. 483. Feest also notes that the "social state principle" (*Sozialstaatsprincip*) forbids leaving persons to their fate. Feest 2006, p. 494.

118 Although they also acknowledge that the duty of the prison authorities to force-feed does not go further than the duty under criminal law to prevent suicide. Kaiser & Schöch 2002, p. 355.

blackmail, the general criminal or ethical obligation to render assistance and the medical imperative of preserving life, the specific dangers of the custodial situation and possible group pressure by like-minded persons as arguments that speak in favour of an extensive duty, or at least, a right to forced medical intervention.[119]

As arguments against an extensive duty or right to apply forced medical treatment in the literature the prisoner's individual constitutional rights are mostly mentioned. Kaiser and Schöch enumerate the constitutional right to self-determination of each patient, human dignity and the freedom of prisoners to decide (on the basis of Articles 1 and 2 of the Basic Law) and possibly religious or ideological beliefs (on the basis of Article 4 of the Basic Law).[120] Feest also refers to the rights as laid down in Articles 1 and 2 of the Basic Law, but more explicitly refers to the right to human dignity (Article 1), the right to free development of personality (Article 2, paragraph 1) and the right to life and physical integrity (Article 2, paragraph 2) in this respect.[121] Kaiser and Schöch also acknowledge that the risks to the prisoner's health and the circumstances under which the treatment takes place (here they seem to refer to the significant force that is needed to restrain the prisoner) can also argue for a limited right to forced medical treatment, in particular in the case of force-feeding.[122]

In the literature, the 1985 amendment and the current Section 101 of the Enforcement of Punishments Act have been strongly criticised.[123] Some authors call the current Section 101 "a legal and political deplorable misconception", similar to Wagner's criticism in 1976.[124] Besides the more fundamental criticism that this Section upholds the possibility to apply force-feeding against the will of the prisoner, elements of the section have also been criticised. Although the unclear terminology "case of danger to life", "serious danger to the prisoner's health" and "immediate danger to life" was removed in 1985, in the current Section 101 there are still terms that cause practical problems. Below, I will briefly go into the most crucial and problematic points in the application of the current Section 101 of the federal Enforcement of Punishments Act for the issue of force-feeding prisoners on hunger strike.

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119 Kaiser & Schöch 2002, p. 354.

120 Kaiser & Schöch 2002, p. 354.

121 Feest 2006, p. 494.

122 Kaiser & Schöch 2002, p. 354.

123 By, for example, Calliess & Müller-Dietz 2008, p. 484 ff, Schwind, Böhm & Jehle 2005, p. 716, Arloth 2005, and Feest 2006, p. 494.

124 Laufs & Uhlenbruck 2002, § 153, Rn 18-34.

3.6. *ZUMUTBARKEIT*

As described above, Section 101 of the Enforcement of Punishments Act requires that, besides danger to the prisoner's life or serious danger to the prisoner's health, coercive medical measures "must be reasonable for the persons concerned and may not entail a serious danger to the prisoner's life or health". Although the term "*zumutbar*" here is translated as "reasonable", this term in my opinion does not completely cover the concept. For this reason, I will refer to this criterion using the German term *Zumutbarkeit*. In the literature and case law no clear-cut criteria to assess this *Zumutbarkeit* can be found, and it is widely acknowledged that it is a vague and undefined term. Still, some general guidelines can be given.

From the view of the prisoner, force-feeding can be *unzumutbar* when the intervention is not carried out *lege artis*. For this reason, only physicians who have the necessary medical qualifications and practical experience may perform the intervention.[125] Also, constitutional rights may play a role. For the prisoner, for example, an intervention can also be *unzumutbar* because in light of Article 4 of the Basic Law, religious reasons play a role.[126]

The forced medical measures must not only be *zumutbar* for the prisoner involved, but for all the parties involved in the application of the forced medical measures, including the physician and other health personnel involved. According to Section 97 (paragraphs 1-2) of the Enforcement of Punishments Act, where direct coercion (such as force-feeding) is ordered by a superior or any other person so authorised, prison officers, including the prison physician, shall be obliged to apply it, except where the order violates human dignity, was not given for official purposes or would constitute a criminal offence. With regard to the aspect of *Zumutbarkeit*, an important question is whether the physician can be required to apply force-feeding to prisoners who actively resist their treatment.

In order to answer the question of whether physicians could be compelled to participate in force-feeding practices, Weichbrodt investigates whether force-feeding can constitute a criminal offence or can be regarded as a violation of human dignity, so that it could constitute an exception to the rule that physicians have to obey superiors when ordering force-feeding in the sense of Section 97.[127] With regard to the first point, the question of whether force-feeding can constitute a criminal offence, he refers to the fact that any invasion of the body of a person fulfils the crime of causing bodily harm in the sense of Section 223 of the Criminal Code and is unlawful, unless it is justified, as in particular by informed consent by the patient, or, as in the case of prisoners, by special justification, such as according to

125 Laufs & Uhlenbruck 2002, § 153, Rn 19-24.

126 Calliess & Müller-Dietz 2008, p. 489.

127 Weichbrodt 1983, p. 312.

Section 101 of the Enforcement of punishments Act (see § 3.2 of this chapter).[128] I agree with Weichbrodt, who concludes that intervention pursuant to Section 101 does not constitute a criminal offence. After all, Section 101 not only obliges the physician to force-feed hunger strikers who are not acting upon their own free will, but also legitimises physicians to force-feed hunger strikers who are in fact acting upon their own free will. In this way, it justifies the interference with the prisoner's physical integrity.

Can force-feeding be regarded as a violation of human dignity, so that it could constitute an exception to the rule that physicians have to obey superiors when ordering force-feeding in the sense of Section 97 of the Enforcement of Punishments Act? It can be argued that most coercive measures carried out against the active resistance of those concerned can be qualified as *unzumutbar*, as they violate human dignity.[129] Weichbrodt notes, however, that with regard to the violation of human dignity, acting against the free will of the prisoner does not always violate his human dignity, as the legal system in many ways overrides the free will of persons, such as for law enforcement purposes and general security. Still, it is acknowledged that the more that forced medical treatment resembles one of the aspects of torture or cruel, inhuman or degrading treatment, the more likely it is to violate human dignity. In the literature, it is acknowledged that cooperation by physicians with the use of excessive and violent force to overcome the prisoner's continuous resistance, and forced medical treatment that requires brutal force several times a day, as the prisoner is continuously fiercely resisting against his treatment by pushing, kicking, scratching, choking and spitting, can be qualified as *unzumutbar.*[130]

The question of whether the physician may designate force-feeding in competent prisoners on hunger strike as *unzumutbar*, and consequently refuse his cooperation to force-feeding on the basis of professional and medical-professional grounds in prisoners remains controversial in the literature.[131]

The criterion of *Zumutbarkeit* is strongly linked to the concrete facts of an individual case. This has the advantage that it gives room for consideration of all the aspects of a specific case by the physician, but it also creates an element of legal uncertainty for prisoners, as all the parties involved in the hunger strike as outlined above must separately assess the reasonableness of the medical coercive measures, and therefore may respond differently to the question of *Zumutbarkeit.*[132] The question of whether force-feeding qualifies as *zumutbar*, in my opinion, strongly

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128 Weichbrodt 1983, p. 312.

129 Feest 2006, p. 497.

130 Laufs & Uhlenbruck 2002, § 153, Rn 19-24 and Weichbrodt 1983, pp. 313-314.

131 Laufs & Uhlenbruck 2002, § 153, Rn 19-24. Arloth 2005, p. 243, states for example that due to ethical considerations certain treatment can be qualified as unzumutbar ("*für Ärzte […] standesrechtliche Überlegungen beachtlich […] können bestimmte Behandlungen unzumutbar machen*").

132 Calliess & Müller-Dietz 2008, p. 489.

depends on the way it is administered. The more force is used in the procedure, for example, the more likely it is to qualify as *unzumutbar.*

3.7. PROPORTIONALITY (*VERHÄLTNISMÄBIGKEIT*)

According to Section 101 of the Enforcement of Punishments Act, the forced medical measure must not only be *zumutbar* but also proportionate (*verhältnismäßig*). As well as being explicitly laid down in this Section, the principle of proportionality is also codified in Section 96, as a part of the twelfth title of the Act, concerning direct coercion. If the coercive medical measure entails a corresponding or even bigger pain of risk than it is intended to cure, this medical measure cannot be justified under Section 101. For such an intervention, the prisoner's consent must be obtained. Nöldeke and Weichbrodt emphasise the fact that forced medical intervention in a resisting prisoner is always connected with a risk to his health and life. If a prisoner strongly resists force-feeding with a tube, there is a danger of suffocation, and in case of force-feeding with a drip there is a danger of cardiac arrest. In cases of continuously non-cooperative prisoners, force-feeding is neither *zumutbar* nor proportionate, according to those authors.[133] Still, this opinion is not shared by everybody. Other authors argue that medical intervention for serious threats to a person's health almost always entails considerable risks, and that these risks have to be accepted.[134]

3.8. WHO DECIDES?

Besides the vague criteria of *Zumutbarkeit* and *Verhältnismäßigkeit* in Section 101 of the Enforcement of Punishments Act, the text of paragraph 3 also raises practical questions. These mainly concern the question of who is authorised to order the coercive medical treatment, the physician or the prison authorities. The text of paragraph 3 of Section 101 stipulates that the coercive medical measures "shall be carried out only upon orders from, and under the supervision of a medical officer". A literal interpretation seems to indicate that the physician is authorised to take the decision on the application of the coercive medical treatment. This is contrary, however, to the last sentence of the first paragraph that seems to indicate that it is the task of the prison authority to decide on this matter. In the literature, this unclear part of the provision on the question of who decides whether the right to force-feeding shall be enforced has lead to discussion and controversy.

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133 Nöldeke & Weichbrodt 1981, p. 285

134 Such as expressed by Heide, as referred to by Schwind, Böhm & Jehle 2005, p. 719. Likewise: Geppert 1976, p. 45.

Some authors have argued that physicians should decide on this question, as this decision is dependent on medical judgments concerning the elements of "danger to life", "serious danger to the prisoner's health", the determination of the free will of the prisoner, and the *Zumutbarkeit* of the measure.[135] Others have argued that the wording of Section 101 shows that the prison authorities have to decide in such matters, after having consulted a doctor. According to them, although the physician determines the way and manner of intervention and monitoring, it is the prison authorities that decide on the question of whether a coercive medical measure such as force-feeding is performed.[136] Nöldeke and Weichbrodt agree with this latter view; in their opinion, the prison director decides *if* the coercive medical measure is performed, and the physician decides *how* it is performed.[137]

As stated in § 3.2 of this chapter, according to Section 178 of the Enforcement of Punishments Act, Section 101 of the Act concerning force-feeding is also applicable to pre-trial detention. With pre-trial prisoners, however, it is not the prison authorities who decide on the application of force-feeding, but it is a investigating judge (*Haftrichter*) who decides on necessary measures or restrictions during detention (see Section 119, paragraph 6, of the Code of Criminal Procedure, *Strafprozeßordnung*).

In deciding on force-feeding of a hunger striker in a particular case, he will usually seek the opinion of the prison doctor. He can consult other doctors with expertise on the matter, and can also consult recorded statements of the prisoner concerning his hunger strike and use these in his decision-making process.[138] The prisoner and public prosecutor are heard by the judge beforehand. The investigating judge will determine whether an obligation or right to intervene exists on the basis of Section 101 of the Enforcement of Punishments Act (see § 3.5 of this chapter). If the investigating judge finds that there is a right, but no obligation, to force-feed the prisoner on hunger strike, force-feeding is declared permissible. In this way, the physician is granted authorisation to determine on the basis of his own professional standards when and how he will perform the intervention.[139] The investigating judge can also anticipate future loss of consciousness of the hunger striker, and determine that in such case the hunger striker must be force-fed, a decision that has to be followed by the physician. If the investigating judge has to rule on a case

135 For example Brühl, as cited by Nöldeke & Weichbrodt 1981, p. 285.

136 For example Geppert, as cited by Nöldeke & Weichbrodt 1981, p. 285.

137 Nöldeke & Weichbrodt 1981, p. 285. Also: Geppert 1983, p. 73.

138 Pfeiffer 2003, p. 678. The uniform federal regulations (*Bundeseinheitliche Verwaltungsvorschriften*) with Section 101 of the Enforcement of Punishments Act that determines that statements by prisoners, which can be relevant for the forced medical intervention, such as force-feeding, must be recorded in writing and signed by the prisoner involved. See § 3.5 of this chapter.

139 Pfeiffer 2003, p. 678.

in which an obligation to force-feed on the basis of Section 101 already exists, the investigating judge can immediately order the physician to apply force-feeding.[140]

3.9. CODIFICATION OF COERCIVE MEDICAL TREATMENT AFTER THE REFORM OF FEDERALISM

Above, I elaborated on Section 101 of the federal Enforcement of Punishments Act. As stated in § 3.2, as a result of the 2006 reform of federalism the execution of all forms of detention became the competence of the federal states. Currently, the federal Enforcement of Punishments Act is still in force in most German states, but the states of Lower Saxony (in 2007), Bavaria (in 2008), Hamburg (in 2009), Baden-Württemberg (in 2009), and Hessen (in 2010) have already passed their own state Enforcement of Punishments Acts.[141] All these Acts contain stipulations that govern coercive measures in the field of health care, that strongly resemble Section 101 of the federal Enforcement of Punishments Act. Still, some differences can be noted.[142]

Compared to the Federal Enforcement of Punishments Act as it was applied in these states, and is still applied in the eleven states that have not yet created their own Acts, the newly created Enforcement of Punishments Acts is much clearer on the question of who decides on the application of force-feeding. In the Bavarian, Hamburg and Hessen Acts, it is determined that force-feeding can only be ordered by the prison authorities in agreement with the physician: force-feeding is only possible if the physician and prison governor agree to it. In this way, these newly created Acts have created an additional requirement for agreement between the physician and prison governor.

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140 Pfeiffer 2003, p. 678.

141 The regulation concerning coercive measures in the field of medical care on a state level can be found in Article 108 of the 2008 Bavarian Enforcement of Punishments Act, Article 84 of the 2009 Hamburg Enforcement of Punishments Act, Article 25 of the 2010 Hessen Enforcement of Punishments Act, Article 61 of the 2009 Baden-Württemberg *Justizvollzugsgesetz* and Article 93 of the 2007 Lower Saxony *Justizvollzugsgesetz*. Article 61 of the 2009 Baden-Württemberg *Justizvollzugsgesetz* is, however, only applicable to pre-trial prisoners (*Untersuchungsgefangenen*).

142 Some of the differences are mostly textually, such as "*ein Ärzt*" in paragraph 3 of Section 101 of the Federal Enforcement of Punishments Act, has been complemented by "*oder Ärztin*" in all the new versions. In Article 108 of the new Bavarian Enforcement of Punishments Act, Article 84 of the new Hamburg Enforcement of Punishments Act and Article 25 of the new Hessen Enforcement of Punishments Act, the term "*Vollzugsbehörde*" in the Federal Enforcement of Punishments Act has been replaced by "*Anstalt*". Also, the new Enforcement of Punishments Acts of Bavaria, Hamburg and Hessen have replaced the first sentence of the first paragraph of Section 101 "Medical examinations and treatment under coercion, as well as forced feeding" (*Medizinische Untersuchung und Behandlung sowie Ernährung*) with the phrase "Medical examinations and treatment under coercion, including necessary procedures for that purpose and force-feeding (*Medizinische Untersuchung und Behandlung einschließlich einer hierfür erforderlichen Ausführung sowie Ernährung*).

As stated in § 3.2 of this chapter, according to Section 178 of the Enforcement of Punishments Act, Section 101 concerning force-feeding is also applicable to pre-trial detention. Since the 2006 reform of federalism, fourteen states have created their own codes of criminal procedure, while Bavaria and Schlweswig-Holstein are still in the legislative process of creating such code.[143] As in the newly created Enforcement of Punishments Acts as discussed above, in these Codes of Pre-trial Procedure all states have also incorporated stipulations that are similar to that of Section 101 of the Enforcement of Punishments Act.[144] Article 28 of the 2009 North Rhine-Westphalia Code of Pre-trial Procedure is formulated in a slight different form: "*When the medical service is of the opinion that the application of coercive medical measures is absolutely necessary and the court orders such measures*, the measures shall be carried out only upon orders from, and under the supervision of a medical officer, except where first aid is rendered in case a medical officer cannot be reached in time and any delay would mean danger to the prisoner's life [emphasis added]".[145] In this stipulation it is explicitly determined that the medical

143 The regulation concerning coercive measures in the field of medical care on a state level for pre-trial prisoners can be found in Article 61 of the 2010 Baden-Württemberg Code of Pre-trial Procedure, Article 21 of the 2009 Berlin Code of Pre-trial Procedure, Article 21 of the 2009 Brandenburg Code of Pre-trial Procedure, Article 21 of the 2010 Bremen Code of Pre-trial Procedure, Article 63 of the 2009 Hamburg Code of Pre-trial Procedure, Article 18 of the 2010 Hessen Code of Pre-trial Procedure, Article 21 of the 2009 Mecklenburg-Western Pomerania Code of Pre-trial Procedure, Article 93 of the 2007 Lower Saxony Code of Pre-trial Procedure, Article 28 of the 2009 North Rhine-Westphalia Code of Pre-trial Procedure, Article 21 of the 2009 Rhineland-Palatinate Code of Pre-trial Procedure, Article 21 of the 2009 Saarland Code of Pre-trial Procedure, Article 21 of the 2011 Free State of Saxony Code of Pre-trial Procedure, Article 21 of the 2010 Saxony-Anhalt Code of Pre-trial Procedure and Article 21 of the 2010 Thuringia Code of Pre-trial Procedure.

144 As in the new Enforcement of Punishments Acts textual differences can be found, such as "*ein Ärzt*" in paragraph 3 of Section 101 of the Federal Enforcement of Punishments Act, has been complemented by "*oder Ärztin*" in the text of nine of the new versions. Besides, the word "*Vollzugsbehörde*" has been replaced by "*Anstalt*" in all new Codes of Pre-trial Procedure. Just like in the new Enforcement of Punishments Acts, in the new created Codes of Pre-trial Procedure of Hamburg and Hessen, the phrase "Medical examinations and treatment under coercion, as well as forced feeding" (*Medizinische Untersuchung und Behandlung sowie Ernährung*), is replaced by the phrase "Medical examinations and treatment under coercion, including necessary procedures for that purpose and force-feeding (*Medizinische Untersuchung und Behandlung einschließlich einer hierfür erforderlichen Ausführung sowie Ernährung*). Also, Berlin, Brandenburg, Bremen, Mecklenburg-Western Pomerania, North Rhine-Westphalia, Saarland and Thuringia have changed the first sentence of the first paragraph of the new stipulations into "*Medizinische Untersuchung und Behandlung sowie Ernährung sind* unbeschadet der Rechte Personensorgeberechtigter *zwangsweise nur bei Lebensgefahr* [emphasis added]", to indicate that if there is a person charged with substitute decision-making tasks, his rights should be respected.

145 "*Hält der ärztliche Dienst die Durchführung von Zwangsmaßnahmen auf dem Gebiet der Gesundheitsfürsorge für unerlässlich und ordnet das Gericht diese an, so dürfen die Maßnahmen nur unter ärztlicher Leitung durchgeführt werden, unbeschadet der Leistung erster Hilfe für den Fall, dass eine Ärztin oder ein Arzt nicht rechtzeitig erreichbar und mit einem Aufschub Lebensgefahr verbunden ist.*"

services must indicate if coercive medical measures are required, and the court is the authority to decide if such measures may be carried out.

3.10. CURRENT SITUATION

Currently, Section 101 of the federal Enforcement of Punishments Act remains the assessment framework for coercive medical measures in prison, including force-feeding, for the states that have not yet created their own Acts. Moreover, in the states' newly created Enforcement of Punishments Acts and Codes of Pre-trial Procedure, the possibility to intervene in a hunger strike through force-feeding is maintained, since, as shown above, in all these newly created Acts, stipulations comparable to Section 101 of the federal Act can be found. In this way, the possibility to force-feed prisoners on hunger strike is safeguarded.

This is remarkable, since high profile collective hunger strikes such as those that led to the creation of Section 101 of the federal Enforcement of Punishments Act in 1976 no longer take place. Nowadays, discussion of the legitimacy of force-feeding prisoners on hunger strike has lost its intensity and its attention of the general public that it generated in the 1970s and 1980s. The practical relevance of Section 101 is low, as coercive medical measures do not occur regularly in German custodial practice.[146] Besides, in the literature it is stated that it is not likely that forced medical treatment will be applied in individual hunger strikes in prison.[147] Ostendorf states that force-feeding will only be considered if the free will of a prisoner is absent.[148] In my opinion, the question of force-feeding is still relevant, since in a prolonged hunger strike a moment will inevitably occur when the prisoner becomes incompetent, and an obligation to intervene through force-feeding arises.

The issue of force-feeding is most controversial in situations where the prisoner has lost consciousness or has lapsed in a coma and has stated when he was still competent (verbally, or in an advance directive) that he refuses any intervention. In such cases it has to be decided whether the prisoner's wishes are respected, or the preservation of life must be prioritised. Arloth states that if the prisoner has indicated that he refuses life-sustaining interventions in such a case, his will has to be respected.[149] Pont, on this point, refers to the WMA that states that physicians who are unable for reasons of conscience to abide by a hunger striker's refusal of treatment or artificial feeding, should make this clear at the outset and refer the

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146 Laue 2005, p. 218. Feest also states about Section 101 "*Für den Vollzugsalltag hat sie […] kaum eine Bedeutung*". Feest 2006, p. 494. Also Arloth 2011, p. 389.

147 Rieckenbrauck in this respect states that a competent prisoner may not be treated against his will, "not even to feel his pulse". Rieckenbrauck 2009, p. 261.

148 Ostendorf 2009, p. 572.

149 Arloth 2011, p. 572.

hunger striker to another physician who is willing to abide by the hunger striker's refusal (Article 15 of the WMA Declaration of Malta). He further notes that the final decision on force-feeding should always be left to the attending physician, without third parties' interests influencing his medical judgment.[150] Nowadays, resistance by the medical profession to forced medical intervention in hunger strikes continues. Prison physicians hereby refer to their professional autonomy. In this respect, Schwind, Böhm and Jehle refer to the lack of freedom for prisoners to select the physician of their own choice, and the fact that the prison physician has to enjoy a minimum level of confidence from his patients, which is not compatible with the application of forced medical treatment by the same physician.[151]

As noted above, the practical relevance of Section 101 is low, its terms are vague and undefined, and forced medical treatment in prisoners is rejected by the medical profession. Why then still safeguard the right to force-feed competent prisoners on hunger strike? According to the literature, the right for the State to intervene in a hunger strike is prompted by the idea that it gives authorities the possibility to be able "to meet unusual challenges flexibly" (*um ungewöhnlichen Herausforderungen flexible begegnen zu können*). This possibility is important, since it gives the State the possibility to execute sentences of the convicted prisoner against his wishes, and to avoid "spectacular deaths, that would publicly discredit the prison system".[152] Apparently, the possibility is maintained to intervene and prevent death in politically highly sensitive collective hunger strikes. In my opinion, the turbulent experiences with the RAF hunger strikes and the political dimension of the most conspicuous hunger strikes in Germany that severely challenged the German prison systems can still be recognised here.

3.11. CONCLUSIONS

The prisoner's legal status and Enforcement Of Punishments Act in general, are underpinned by the rights and principles of the 1949 German Basic Law. The German Federal Constitutional Court has ruled that the requirement of consent to medical treatment is founded in the patient's right to physical integrity and self-determination, as founded in Article 2, paragraph 1, of the Basic Law. Medical intervention without the patient's consent is considered a violation of the patient's physical integrity and his right to self-determination. Section 196 of the Enforcement of Punishments Act determines that the prisoner's right to physical integrity and freedom of the person can be restricted. This is the case for coercive medical treatment on the basis of Section 101.

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150 Pont 2009-I, p. 27.

151 Schwind, Böhm & Jehle 2005, p. 716.

152 Kaiser & Schöch 2002, p. 355.

This Section has been mostly discussed in relation to force-feeding prisoners on hunger strike, and was incorporated in the law for exactly this purpose. The collective, long-term and politically motivated hunger strikes by RAF prisoners in the 1970s and 1980s strongly influenced the development German policy on force-feeding hunger strikers. These RAF prisoners gained a lot of publicity by using hunger strikes as a means to underline their political resistance. During the second major hunger strike by RAF prisoners in 1973, force-feeding was used for the first time. This hunger strike, and the death of Holger Meins, led the discussion to force-feeding to a first climax, resulting in 1976 in the creation of Section 101 of the Enforcement of Punishments Act. This stipulation contained an obligation for the prison authority to intervene in case of danger to life or serious danger to the prisoner's health, if the prisoner was not acting upon his own free will. No duty to force-feed a prisoner on hunger strike existed when the prisoner was acting upon his own free will, except when immediate danger to his life existed. The political compromise of Section 101 of the Enforcement of Punishments Act was severely criticised by legal scholars. The German Medical Assembly had spoken out against force-feeding of competent hunger strikers in 1974, and reiterated this statement in 1981. Force-feeding practices in prison remained controversial. Many physicians (especially in Berlin) refused to apply force-feeding, while West German physicians participated in force-feeding practices, even in an early stage of the hunger strike.

The debate on force-feeding (again) resulted in legislative reform after a collective RAF hunger strike in prison, and the death of Sigurd Debus while being force-fed. As a result, in 1985 the legislator removed the State's duty to undertake forced medical treatment against the prisoner's express wishes in case of immediate danger to life. With this adjustment of Section 101, the legislator attempted to prevent and discourage future hunger strikes by clarifying the expected response, and making clear that lives would no longer be artificially maintained. This new approach was reflected in the 1989 hunger strike by RAF prisoners in which force-feeding was no longer applied and hunger strikers were only observed medically.

Currently, when the demands of Section 101 of the federal Enforcement of Punishments Act are met, the authorities are under an *obligation* to intervene if the hunger striker is not acting upon his free will, while in the case of a hunger striker who is acting upon his free will, the authorities have the *right* to intervene in his hunger strike. Section 101 was controversial from its inception, and although it has been subject to restrictive changes, in many aspects it is still controversial (for example on the question of the element of *Zumutbarkeit*). The right and obligation to intervene in hunger strikes, however, is safeguarded, not only in Section 101 of the federal Enforcement of Punishments Act, but also in the recently created Enforcement of Punishments Acts on a state level.

Nowadays, the practical relevance of Section 101 is low and the medical profession remains opposed to forced medical treatment in prison. Although force-feeding is no longer applied to competent prisoners, in prolonged hunger strikes the right to

intervene will inevitably turn into an obligation to intervene if the hunger striker is no longer competent to decide, or has lapsed into a coma. A difficult dilemma then arises if the prisoner has stated when he was still competent to decide (for example in an advance directive) that he refuses any intervention. The possibility to intervene seems to be motivated by the desire to prevent death in politically highly sensitive hunger strikes. In my opinion, this is a legacy of the past, and the experience with the conspicuous RAF hunger strikers in prison that severely challenged the German prison system.

4. ENGLAND AND WALES

4.1. INTRODUCTION

Nowadays, England and Wales have a liberal approach towards force-feeding prisoners on hunger strike. However, this has not always been the case. At the beginning of the twentieth century, and for many more years after, force-feeding of female suffragettes in the UK was justified on paternalistic grounds. Over the years, there has been a change in emphasis with a shift towards the protection of the individual's right to self-determination and respect for the patient's and prisoner's right to accept or to refuse medical treatment. Government policy officially changed in 1974 with the statement of the Home Secretary that prison physicians were not obliged to feed a prisoner artificially against his will. Unlike the highly political RAF hunger strikes in Germany in the 1980s, the politically charged IRA hunger strikes did not induce a change in policy on force-feeding, but only demonstrated the new policy as announced in by the Home Secretary in 1974. Currently, a prisoner or detainee has the right to go on hunger strike and cannot be treated against his will, which may result in his death in case of a prolonged hunger strike.

Below, I will go into the legal framework for the assessment of force-feeding in England and Wales. I will outline the development of policy concerning force-feeding in chronological order, beginning with the force-feeding of suffragettes on hunger strike, going on to the changed policy in 1974 as announced by the Home Secretary, and concluding with the cases of *R v Home Secretary, ex parte Robb* and *R v Collins, ex parte Brady* in which the current policy on force-feeding in England and Wales is represented. After this, I will briefly deal with deaths as a result of a hunger strike and offer conclusions.

4.2. LEGAL FRAMEWORK

When considering the legal framework of force-feeding in England and Wales, it is important to denote the difference between the civil law systems of the Netherlands and Germany on the one hand, and the common law system of England and Wales

on the other. The legal framework in England and Wales comprises common law and statute law. The Human Rights Act 1998 (in force since October 2000) brings the rights set out in the ECHR into domestic law. Accordingly, all public authorities are required to act in accordance with the rights as enshrined in the Human Rights Act 1998, and statutes must be interpreted in line with it. Before the entry into force of the Human Rights Act, violations of ECHR rights could only be addressed in Strasbourg. Nowadays, those who believe their rights under the ECHR have been violated also have recourse to the UK courts. As will been shown in the following sections, policy on coercive medical treatment, as well as policy on force-feeding of prisoners and detainees, has mainly been created and developed in case law.

Although it is not laid down in a Constitution or Basic Law, such as in the Netherlands and Germany, the principle of the inviolability of a person's body is also acknowledged in case law in England and Wales. The principle that every person's body is inviolate and proof against any form of physical molestation was acknowledged in *F v West Berkshire Health Authority*.[153] On the basis of the principle of self-determination, the patient's wishes must be respected. If an adult of sound mind refuses to consent to treatment or care by which his life might be prolonged, the doctors responsible for his care must give effect to his wishes, even when they do not consider it to be in his best interest to do so. In *Re T (Adult: Refusal of Treatment)* it was acknowledged that "[p]rima facie every adult has the right and capacity to decide whether or not he will accept medical treatment, even if a refusal may risk permanent injury to his health or even lead to premature death". In this respect, it does not matter if the reasons for the refusal are rational or irrational, unknown or even non-existent.[154] An exception to this rule exists where a patient has been rendered temporarily incompetent and emergency treatment is required.[155]

As with people who are at liberty, competent prisoners have the right to consent to or refuse treatment. In the 1984 case of *Freeman v Home Office* a prisoner, while serving a term of life imprisonment, was administered drugs by force against his consent. He contested the fact that a valid free and voluntary consent cannot be given by a person such as the plaintiff, who is in prison, to a prison medical officer who is an officer of the prison having a disciplinary role in relation to him. Although the judge recognised that a prison doctor can influence a prisoner's situation and prospects, he ruled that a prisoner is as capable as any other person of giving consent to medical treatment.[156] In 2002, the Department of Health published a booklet for

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153 *F v West Berkshire Health Authority* [1989] 2 All ER 545 [1990] 2 AC 1, as referred to in *R v Home Secretary, ex parte Robb* [1995] 1 All ER 677.

154 *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, p. 115. Reiterated in *Re C (Adult: Refusal of Treatment)* [1994] 1 W.L.R. 290, p. 294.

155 Livingstone, Owen & Macdonald 2008, p. 277, referring to *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1.

156 *Freeman v Home Office* [1984] 1 All ER 1036.

prison health care staff to provide guidance on the issue of seeking consent from people in prison, entitled *Seeking Consent: Working with People in Prison*. In this, it is confirmed that "[t]he fact that a patient is also a prisoner does not affect their right to determine whether or not to accept treatment where they have the mental capacity to make such a decision". Furthermore, it recognises that "[p]eople with the capacity to take a particular decision are entitled to refuse any treatment being offered, even if this will clearly be detrimental to their health. No competent adult (defined as a person aged 18 or over) can be treated against their will."[157]

It can be concluded that a physician may not apply medical treatment to a competent adult prisoner against his wishes, the same as for patients in the outside world, even if the proposed medical treatment is obviously in the prisoner's best interests. Consistent with this, a competent adult patient's anticipatory refusal of consent (laid down in an advance directive or living will) remains binding and effective notwithstanding that the patient has subsequently become and remains incompetent.[158]

For minors, the general rule is that a physician is not allowed to treat a patient without his consent or the consent of someone who is authorised to give it. Until the moment a child is capable of giving consent, a parent or person with parental responsibility will consent on the child's behalf. In principle, a physician may only overrule parental consent to treat the child when justified by exceptional circumstances, such as an emergency, parental neglect, abandonment of the child or the inability to find the parents.[159] At the age of sixteen, minors are provided with a statutory right to consent to their own medical treatment under Section 8 of the Family Law Reform Act 1969. Where a minor by virtue of this Section has given consent to medical treatment, consent from his parents or guardian is no longer required (paragraph 1). As with adults, they are assumed to have capacity, unless demonstrated otherwise.

Before the age of sixteen, minors may be in a position to give consent for their own medical treatment. In the case of *Gillick v West Norfolk and Wisbech*, Lord Scarman stated that "as a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed. It will be a question of fact whether a child seeking advice has sufficient understanding of what is involved to give a consent valid in law." [160] Accordingly, minors who have "sufficient understanding of what

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157 Department of Health, *Seeking Consent: Working with People in Prison,* 5 July 2002, under 1.1 and 2.5, available at <http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4034353.pdf> (last accessed on 3 February 2012).

158 *HE v NHS Trust A and AE* [2003] EWHC 1017 (Fam).

159 Harper 1999, pp. 8-9.

160 *Gillick v West Norfolk and Wisbech AHA* [1985] All ER 402.

is involved and intelligence to enable them to understand fully what is proposed" have the capacity to consent to medical treatment. This has become known as the "Gillick" test for competence.[161] If the minor is "Gillick competent" to make a specific decision concerning medical treatment, no consent from the person with parental responsibility has to be obtained.[162] Besides the capacity to give consent, a minor's consent must also be given voluntarily in order to be valid, which is often a delicate issue in such decisions. When a minor of sixteen or seventeen years old under Section 8 of the Family Law Reform Act 1969, or a minor under 16 who is "Gillick competent", voluntarily refuses medical treatment, this refusal is to be respected. It can only be overruled if it would in all probability lead to the death or to severe permanent injury of the minor.[163]

The fact that a person has a mental illness does not automatically mean they lack capacity to make a decision about medical treatment.[164] In the case of *Re C (Adult: Refusal of Treatment)*, C suffered from paranoid schizophrenia and was detained in Broadmoor secure hospital. Because of gangrene in his leg he was advised by doctors to undergo an amputation in order to save his life, which C refused. He sought an injunction to restrain his doctors from amputating his leg without his consent. Thorpe J. granted this injunction, stating that patients who have capacity can make their own decisions to refuse treatment, even if those decisions appear irrational to the doctor or may place the patient's health or their life at risk.[165] In this case, the standard legal definition of capacity was developed, which was subsequently cited in other cases, and has become known as the "Re C test". The High Court held that

> "[i]n determining whether that person had sufficient capacity to refuse treatment, the question to be decided was whether it had been established that his capacity had been so reduced by his chronic mental illness that he did not sufficiently understand the nature, purpose and effects of the offered medical treatment. That in turn depended on whether he had comprehended and retained information as to the proposed treatment, had believed it and had weighed it in the balance when making a choice."

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161 Sometimes this is also referred to as "Fraser competency", named after the judge who ruled on this case.

162 The 2009 document *Reference Guide to Consent for Examination or Treatment* of the Department of Health adds in this respect under 3.5 that "It is, however, good practice to involve the young person's family in the decision-making process –unless the young person specifically wishes to exclude them – if the young person consent to their information being shared."

163 Department of Health, *Reference Guide to Consent for Examination or Treatment*, second edition 2009, pp. 32-33. Available at <http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103643> (last accessed on 3 February 2012).

164 See also Ch. 2, § 6.2.

165 *Re C (Adult: Refusal of Treatment)* [1994] 1 WLR 290 [1994] 1 All ER 819.

Accordingly, for a patient to have capacity he must be able

a) to understand and retain relevant information on the proposed medical treatment

b) to believe that information, and

c) to weigh that information in the balance to make a decision on the proposed medical treatment.

Since its entry into force on 1 October 2007, the Mental Capacity Act 2005 provides a statutory framework for making treatment decisions for people in England and Wales aged sixteen or over who lack capacity. It applies in all settings, so it is also applicable to prisoners and detainees. It provides clarity on decision-making for persons who lack capacity and gives direction on how those decisions should be made. The Mental Capacity Act 2005 sets out the requirement for the assessment of a person's capacity. It defines a person who lacks capacity as a person who is "unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain" (Section 2). It does not matter if this impairment or disturbance is permanent or temporary. Capacity is task and time-specific: people may have capacity to consent to some interventions but not to others, or may have capacity at some times but not others. One of the five statutory principles of this Act as laid down in the first section, states that "[a] person must be assumed to have capacity unless it is established that he lacks capacity" (paragraph 2). Accordingly, the basic assumption is that every patient, prisoner and detainee has capacity, unless it is proven otherwise. A decision to refuse food is an unwise decision in the eyes of many, but it is no evidence the person lacks capacity. In the Mental Capacity Act 2005, a test for capacity is formulated, which largely resembles the "Re C test".

According to paragraph 3, a person lacks capacity if he is unable to do one of more of the following things:

a) understand the information relevant to the decision

b) retain that information

c) use or weigh that information as part of the process of making the decision, or

d) communicate his decision (whether by talking, using sign language or any other means).

When capacity is lacking, a person is not, or no longer, able to give valid consent. Their right to decide whether to accept or reject proposed medical care may be overridden, and others will make the decision concerning medical treatment for them. If a person is not capable of giving or refusing consent, medical treatment

can still be provided, unless the patient has clearly refused it in advance. As a basic rule, all treatment or care provided must be in the person's "best interests". Those close to the incapacitated person should be involved in the decision-making (unless the person has made it clear that they do not want such involvement), but no-one (not even a spouse or close relative) can give consent on behalf of adults incapable of consenting for themselves.[166] Decisions relating to a patient's capacity to give and withhold consent are a matter for the responsible treating doctor, in consultation with any other members of the healthcare team who are on duty at the time. In case of doubt in one of the points mentioned above, a second opinion from another doctor should be acquired.[167] The courts have determined that a person's "best interests" is not limited to what would benefit them medically. Their spiritual and religious welfare, their general well-being, their current wishes, and views and beliefs that they held before they lost capacity should also be taken into account.[168] Besides the Mental Capacity Act 2005, guidance on the assessment of capacity and deciding for persons who lack capacity is provided in the Mental Capacity Act 2005 Code of Practice by the Department for Constitutional Affairs.[169]

The Mental Capacity Act 2005 also covers the issue of "advance decisions" (Sections 24-26). An advance decision, in the sense of this Act, means a decision by a person of 18 years and over with capacity that if "at a later time and in such circumstances as he may specify, a specified treatment is proposed to be carried out or continued by a person providing health care for him, and at that time he lacks capacity to consent to the carrying out or continuation of the treatment, the specified treatment is not to be carried out or continued" (Section 24, paragraph 1). In other words: the patient with capacity decides at which moment he will no longer have capacity to decide for himself. In hunger strikes, an advance decision is mostly drafted to ensure that in the case of incapacity (for example, because he becomes confused, or he has lapsed into a coma) no medical treatment or artificial feeding is performed. According to the Mental Capacity Act 2005, such an advance directive and alteration need not be in writing, and can be withdrawn at any time when the person has capacity to do so (Section 24, paragraphs 3-5). A valid and applicable advance decision to refuse treatment has the same force as a "normal" decision to refuse treatment, and must be followed by the treating physician and other healthcare professionals, even if this leads to the person's death. In their

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166 Department of Health, *Seeking Consent: Working with People in Prison,* 5 July 2002, under 3.2-3.3, available at <http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4034353.pdf> (last accessed on 3 February 2012).

167 Ibid., under 3.7.

168 Ibid., under 3.7.

169 Available at <http://www.justice.gov.uk/protecting-the-vulnerable/mental-capacity-act> (last accessed on 17 February 2012).

Reference Guide to Consent for Examination or Treatment, the Department of Health summarises the requirements of a valid and applicable advance directive, which are

a) the person must be 18 or over,

b) the person must have the capacity to make such a decision,

c) the person must make clear which treatments they are refusing,

d) if the advance decision refuses life-sustaining treatment, it must be in writing, it must be signed and witnessed and it must state clearly that the decision applies even if life is at risk.[170]

The admission of persons with mental disorders without their consent in England and Wales is governed by the Mental Health Act 1983, which has been significantly amended by the Mental Health Act 2007.[171] The Mental Health Act 1983 describes the circumstances when a mentally disordered person can be placed in custody and/or can be compulsory treated. According to the Department of Health, the main purpose of this legislation is "to ensure that people with serious mental disorders which threaten their health or safety or the safety of the public can be treated irrespective of their consent where it is necessary to prevent them from harming themselves or others."[172]

As shown in this section, consent is needed before medical treatment can be performed on patients. This can be different for patients covered by the Mental Health Act 1983. This act contains the possibility to forcibly apply medical treatment in such patients. Part IV of the Act governs the issue of consent to treatment. These stipulations all apply to treatment for mental disorder. They are not applicable to the medical treatment of physical disorders, unless they are diagnosed to be a symptom or underlying cause of the mental disorder. According to Section 57, some medical treatments, such as any surgical operation for destroying brain tissue or for destroying the functioning of brain tissue, are so invasive that they cannot automatically be performed even if the patient consents to it, and they need additional safeguards, such as a second opinion. In such cases, three people (one physician and two other persons not being registered medical practitioners who have been professionally concerned with the patient's medical treatment, one shall be a nurse, and the other shall be neither a nurse nor a registered medical practitioner) have to certify in

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170 Department of Health, *Reference Guide to Consent for Examination or Treatment*, second edition 2009, under 47. Available at <http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103643> (last accessed on 3 February 2012).

171 Where in the following I refer to the Mental Health Act 1983, I mean the Mental Health Act 1983 as amended by the Mental Health Act 2007.

172 <http://www.dh.gov.uk/en/Healthcare/Mentalhealth/DH_078743> (last accessed on 3 February 2012).

writing that the patient is capable of understanding the nature, purpose and likely effects of the treatment in question and has consented to it.

Section 58 of the Mental Health Act 1983 applies to medication for the patient's mental disorder and electroconvulsive therapy (under Section 58a). This treatment requires consent or a second opinion. If the patient consents to the treatment, the approved clinician in charge of it must certify in writing that the patient is capable of understanding its nature, purpose and likely effects and has consented to it. If a patient is capable of understanding the nature, purpose and likely effects of the proposed medical treatment and does not consent, or if he is not capable and consents to the treatment, the medical treatment can still be provided if a registered medical practitioner – not being the responsible clinician or the approved clinician in charge of the treatment – certifies in writing that the patient is not capable of understanding the nature, purpose and likely effects of the proposed medical treatment, but is of the opinion that it is appropriate for the treatment to be given. The registered medical practitioner concerned must consult two other persons who have been professionally concerned with the patient's medical treatment, one being a nurse, and the other being neither a nurse, nor a registered medical practitioner. Medication for the person's mental disorder without the patient's consent is allowed for three months, starting from the moment it was first administered. In these first three months, the treatment can be given without the second opinion as required by Section 58 (Section 58, paragraph 1 under b). After this period, the requirements of Section 58 have to be fulfilled, necessitating the patient's consent or a second medical opinion.

In Section 62, concerning urgent treatment, it is determined that the requirements of Sections 57 and 58 do not have to be followed if treatment is immediately necessary to save the patient's life, is immediately necessary to prevent a serious deterioration of his condition, is immediately necessary to alleviate serious suffering by the patient (so long as the treatment is not irreversible or hazardous), or is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or to others (so long as the treatment is neither irreversible nor hazardous).

Besides the possibility of providing medication without the patient's consent for urgent treatment, another exception to the rule that patients must consent before medical treatment can be performed is created by Section 63, which determines that "[t]he consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering if the treatment is given by or under the direction of the approved clinician in charge of the treatment." This Section can, under certain circumstances, provide a legal basis for administering tube feeding to mentally ill hunger strikers who are detained under the Mental Health Act 1983.[173]

[173] See § 4.8 of this chapter.

4.3. JUDICIAL REVIEW

As will become clear in § 4.9 et seq., the current policy in England and Wales is to regard force-feeding as a medical matter, to be decided on by the physician. Still, courts may be asked to assess physicians' decisions, also concerning force-feeding, as the cases enumerated in § 4.6 and 4.8 show. In the case of *Airedale NHS Trust v Bland*, Lord Goff elaborated on the role of the physician, the courts and their relationship

> "The truth is that, in the course of their work, doctors frequently have to make decisions which may affect the continued survival of their patients, and are in reality far more experienced in matters of this kind than are the judges. It is nevertheless the function of the judges to state the legal principles upon which the lawfulness of the actions of doctors depend; but in the end the decision to be made in individual cases must rest with the doctors themselves."[174]

In this, a clear division between the courts' and the physicians' task can be recognised: the physician has to decide in individual cases, within legal margins that are set by the courts. Still, Lord Goff also acknowledges the reciprocal relationship between physicians and the courts, by stating that

> "In these circumstances, what is required is a sensitive understanding by both the judges and the doctors of each other's respective functions, and in particular a determination by the judges not merely to understand the problems facing the medical profession in cases of this kind [the case concerned the discontinuation of life-sustaining treatment and medical support to a patient in a vegetative state] but also to regard their professional standards with respect. Mutual understanding between the doctors and the judges is the best way to ensure the evolution of a sensitive and sensible legal framework for the treatment and care of patient, with a sound ethical base, in the interest of the patients themselves."

In England and Wales, judicial review is a form of court proceedings in which a judge reviews the lawfulness of a decision or action by a public body. It is merely a challenge to the way in which a decision has been made, to investigate whether the law has been correctly applied and the right procedures have been followed.[175] Permission for judicial review must be obtained from the Administrative Court, a division of the High Court of Justice. For judicial review, it is required that the following can be answered in a positive sense: 1) is the application within the time limit, i.e. promptly and within three months from the date of the decision? 2) is the

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174 *Airedale NHS Trust v Bland* [1993] 1 All ER 821 [1993] AC 789, at 871.

175 Public Law Project Information Leaflet 4, the Public Law Project 2006, p. 1. Available at <http://www.publiclawproject.org.uk/downloads/GuideToJRProc.pdf>.

body and decision or action subject to judicial review? (the body must be a public body, and the decision must be public in nature) 3) is judicial review the correct procedure to follow? (judicial review is only possible when used as a last resort, when there is no alternative remedy available). The grounds for judicial review are illegality, irrationality and unfairness. If the application for judicial review is successful, the court can grant a remedy by making of one of six orders: a quashing order, a prohibiting order, a mandatory order, a declaration, an injunction and/or damages.[176]

Local authorities and health authorities qualify as public bodies, whose decisions, including decisions on forced medical treatment, may be challenged by judicial review. For some forced medical interventions, court approval is essential. This is the case for, *inter alia*, withdrawing artificial nutrition and hydration from a patient who is in a persistent vegetative state or where there is doubt about a person's capacity and the proposed intervention is controversial or sensitive; decisions that are so serious that each case must be brought before the courts for independent review.[177] The High Court's Family Division deals with issues of medical treatment, particularly in relation to questions of (in)competency and consent.

Most case law concerning force-feeding involves those sanctioned under the terms of the Mental Health Act 1983, particularly under Section 63, such as the case of *R v Collins, ex parte Brady*, where a prisoner on hunger strike applied for judicial review of the decision of his medical officer to force-feed him pursuant to Section 63 of the Mental Health Act 1983 (see § 4.8 of this chapter). In this way, courts can become involved when there is doubt about a person's capacity to refuse medical treatment. In such cases, the court may issue a declaration that the patient lacks capacity to make the decision in question and that, despite the patient's refusal, providing treatment would be lawful.[178] In this way, the court legitimises intervention by the physician in an individual case.

Not only cases where there is doubt about the hunger striker's capacity to refuse medical treatment have appeared before the court. In the 1995 landmark case concerning force-feeding prisoners on hunger strike under English law, *R v Home Secretary, ex parte Robb*, the Home Secretary sought declarations that the Home Office, prison officials and the physicians and nursing staff responsible for the prisoner 1) might lawfully observe and abide by his wish to refuse food, and 2) might lawfully abstain from providing him with hydration and nutrition (by artificial means or otherwise), for so long as he retained the capacity to refuse it (see § 4.6 of this chapter). With this, the Home Secretary sought permission to refrain from intervention in the hunger strike to preserve the life of the hunger striker. In this

176 Public Law Project Information Leaflet 4, the Public Law Project 2006, pp. 2-3. Available at <http://www.publiclawproject.org.uk/downloads/GuideToJRProc.pdf>.

177 BMA 2004, p. 119.

178 BMA 2004, pp. 118-119.

case, the court set the legal margins within which the physician has to decide in individual case. In this, the role of the physician, the court and their relationship as identified by Lord Goff in the case of *Airedale NHS Trust v Bland* is reflected. These legal margins have been adhered to until today, and have been translated in current policy on hunger strikes in England and Wales, as will be demonstrated in § 4.9 et seq. of this chapter.

4.4. FORCE-FEEDING OF SUFFRAGETTES

Having outlined the legal framework for consent to medical treatment for patients and prisoners, I will make a giant leap back in time to investigate the origins of the policy on force-feeding of prisoners on hunger strike, as the legal precedent for force-feeding was created in the early twentieth century (which is significantly different from the policies on force-feeding in the Netherlands and Germany, which were mainly created and shaped in the 1970s and 1980s). From the early twentieth century onwards, the so-called suffragettes, women campaigning for women's suffrage, went on hunger strike in several British prisons. Emmeline Pankhurst was one of the founders of the Women's Social and Political Union in the UK (the suffragette movement). The suffragettes, mostly well-educated women, wanted the government to acknowledge women's rights, in particular women's right to vote on equal terms with men. During their time in custody (mostly because of damaging property, as a part of their activities), they went on hunger strike many times, *inter alia*, to obtain equality of treatment with prisoners convicted of a like offence, and for justice in observance of the prison rules. Marion Dunlop was the first to undertake such action in 1909. All these hunger strikers were force-fed. As a result of malnourishment, but also as a result of fierce force-feeding practices, some of them died. In the case of *Leigh v Gladstone*, these force-feeding practices were approved.[179]

In *Leigh v Gladstone*, Marie Leigh had been convicted because of suffragette activities, i.e. resisting the police and disturbing a meeting. During her time in custody, she was force-fed by warders after three days of hunger-striking, and she sued for trespass of the person, claiming damages for assault and an injunction to prevent a repetition of the acts complained of. The force-feeding applied to her, and also to other suffragettes, was performed in a fairly brusque fashion. Doctors described these practices as following

> "Between the teeth a wooden block is placed, containing a hold through which a greased stomach tube is passed. This process is performed once or twice a day and may be repeated if vomiting occurs. Where resistance is encountered, a steel

[179] *Leigh v Gladstone* [1909] 26 TLR 139.

> clamp is used to prise open the mouth, and several people may be required to hold the subject still."[180]

Lord Alverstone, the Lord Chief of Justice, directed the jury and considered that it was the duty of the officials to preserve the health and life of the prisoner. He acknowledged that if the prisoner was force-fed when it was not necessary, the defendants ought to pay damages. But, medical evidence showed that if the physician in this case had allowed the plaintiff to fast for a few days longer, she would have died as a consequence, just like "two other ladies who were also guilty of this wicked folly".[181] According to Lord Alverstone, it was not assault to force-feed the prisoner on hunger strike against her will if it was to save her from injury, as the prison officials were under the duty to preserve the health of the prisoners in their custody and *a fortiori* to preserve their lives, and the feeding of this prisoner by force was necessary for that purpose.[182]

In this case, and also in subsequent force-feeding cases before 1974, paternalistic arguments played a great role. As Brockman notes, the principle of beneficence provided the basis for force-feeding in competent hunger strikers. It was felt that "doctor knows best", and force-feeding was based on a greater-good argument which allowed prison authorities to act against the prisoner's express wishes.[183] In this respect, medical authority was hardly questioned, and clinical judgment was considered decisive.

In 1913, the Prisoner's Temporary Discharge of Ill Health Act, what would become known as the Cat and Mouse Act, was introduced. On the basis of this Act, prisoners who became sick would be released, and after recovering, were arrested and taken back to prison. This Act was created for the specific situation of suffragettes on hunger strike, and was not utilised in later hunger strikes.[184] As a result, some of the suffragettes were imprisoned and released more than ten times.

Physicians participated in force-feeding practices on suffragette prisoners. Nevertheless, medical opinion was not undisputed on the issue of force-feeding. In a 24-hour period in July 1912, 117 medical practitioners signed a letter against the force-feeding of suffragette prisoners, in response to a statement by Mr McKenna, the then Home Secretary in the House of Commons, who had stated that "feeding by tube, if carried out in accordance with the usual rules of procedure, is neither dangerous not painful". Although he admitted that force-feeding of "recalcitrant prisoners" is "a most unpleasant process", it is necessary "to guard against any

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180 BMA archive, cited in BMA 1992, p. 120.

181 *Leigh v Gladstone* [1909] 26 TLR, p. 142.

182 *Leigh v Gladstone* [1909] 26 TLR 139.

183 Brockman 1999, p. 453.

184 Zellick 1976, p. 155.

risk to health and to minimise the discomfort to the prisoner", he stated.[185] In their letter, the medical practitioners emphasised that force-feeding, if the patient resists, is in fact attended by grave medical risks, unforeseen accidents are liable to occur, and that the subsequent health of the patient may be seriously injured by the force-feeding applied.[186] In August of the same year, three prominent physicians published a preliminary report on the force-feeding of suffragette prisoners, in which they refuted the Home Secretary's statement that the practice of force-feeding was unattended by danger or pain, after having considered statements of 102 of the suffragette prisoners, of whom 90 had been subjected to force-feeding, and having examined a large number of these prisoners after their release.[187] On the basis of their findings, they qualified these force-feeding practices as prison torture that had led to severe physical and mental suffering, and concluded that "the position in regard to forcible feeding of suffrage prisoners must be considered anew".[188]

Despite this resistance, some physicians appeared to be willing to apply force-feeding, as force-feeding practices in prison continued. One of those physicians, Mr Harman, responded to the report mentioned above in a letter to the editor of the *Lancet* and showed his willingness to apply force-feeding, stating that "[a]s long as the law exists, which declares suicidal attempts a crime, so long must we agree that forcible feeding is emphatically necessary for people who adopt starving […] and it is certainly as necessary and ordinary a treatment to preserve their health, as any other means with irresponsible people". In his view, he was obliged to apply force-feeding as it was a suicide attempt and a criminal offence, and paternalistic behaviour was justified, as the hunger strike was evidence of capriciousness behaviour. This opinion was not uncommon. Although in most suffragette cases (including *Leigh v Gladstone*), there was no evidence that the hunger striker was incompetent, some physicians argued that refusal of food in itself was evidence of insanity.[189] This paternalistic view towards hunger strikers also resounds in the last phrase of Harman's letter:

> "Mr. McKenna deserves the best thanks of the community in resisting sentimental class clamour, and in maintaining the discipline of places which are, after all, for evildoers. The only good to be hoped for from such a (in every respect regrettable) report is that suffragettes seeing it may cease to do evil and learn to do well."[190]

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185 Statement by Mr McKenna, to a question in the House of Commons by Mr Goldman, as cited in Savill, Moullin & Horsley 1912–1.

186 Letter as cited by Zellick 1976, p. 157.

187 Savill, Moullin & Horsley 1912-2.

188 Savill, Moullin & Horsley 1912-1, p. 551.

189 See, for example, expert witness Sir R. Douglas Powell in the case of *Leigh v Gladstone* who stated that "if an ordinary person refused to take food could not be regarded as sane" (p. 142).

190 Harman 1912, p. 671.

The decision in *Leigh v Gladstone* concerning force-feeding was much criticised, not only in the medical field, but also by legal scholars. Zellick, for example, deemed this legal precedent as "a first-instance unreasoned direction to a jury apparently without adequate legal argument on the fundamental point with which it deals".[191] Kennedy was also critical, stating that "this is a decision made at a particular time in response to a particular situation against a particular political background", and deems it "poor material on which to build any general proposition", and "an anomalous departure from the general principle of self-determination".[192] Street questioned whether this ruling was not too strongly directed towards the specific situation, and wondered whether the decision would have been the same "if the plaintiff had neither been a Suffragette, nor in prison".[193] In my opinion, the view as illustrated by Lord Alverstone in *Leigh v Gladstone* can be explained by the particular context of dramatic political conflict between the suffragette movement and the British Government at the time. The force-feeding then used was part and parcel of the oppressive governmental attitude towards the suffragette movement. In this respect, I agree with the criticism of Kennedy and Street.

During the suffragette period and for many years after, the Home Secretary was under the obligation to preserve the health and life of hunger strikers by means of force-feeding. Force-feeding was policy under successive British governments, and force-feeding practices in prison were not uncommon.[194] The techniques used in these practices remained the same as used during the suffragette period at the beginning of that century.

4.5. POLICY CHANGED: THE 1974 HOME SECRETARY'S STATEMENT ON FORCE-FEEDING PRISONERS ON HUNGER STRIKE

After the hunger strikes by the suffragettes, for long time there was no public discussion on the legitimacy of force-feeding hunger strikers in prison in the UK. This changed in 1974, when the evolution of a policy concerning force-feeding in hunger strikers took place. Although in the 1960s there was to some degree a transition from strict force-feeding to more prisoner-centred treatment, it was not until the spring of 1974, when young Irish prisoners held in Brixton prison were

191 Zellick 1976, p. 160.

192 Kennedy 1976, p. 227.

193 Street 1972, p. 82.

194 In 1973, for example, 25 prisoners, two of them women, on hunger strike were force-fed. Zellick 1976, p. 154.

force-fed throughout their hunger strike that lasted from November 1973 to the summer of 1974 that a change occurred.[195]

On 30 January 1974, the then Home Secretary Robert Carr continued to defend force-feeding practices, by stating that

> "Of course, artificial feeding, particularly when accompanied by force, against the wish of the prisoner, is horrible and terrible. It is resorted to only as a last resort and as an alternative to endangering the life of the prisoner – an alternative we have never regarded as being acceptable in this country."[196]

Although Carr deemed force-feeding "horrible and terrible", it was to be preferred to the death of the hunger striker. Within six months, however, the policy changed drastically with the installation of the new Home Secretary, Roy Jenkins. He was confronted with two young Irish prisoners on hunger strike, the Price sisters, who challenged the right of the Home Office to force-feed in any case other than that where refusal of food arose from a medical or psychiatric illness. This case brought the matter back in the public eye, it raised a furore within the medical profession, and brought about a radical evolution of policy. In response to the proceedings against the Home Office by the Price sisters, on 17 July 1974, Roy Jenkins made a statement in the House of Commons about future medical policy for the assessment and the management of hunger strikers in prison. As this statement marked a dramatic change on this issue, in my opinion, it merits extensive reproduction.

> "The doctor's obligation is to the ethics of his profession and to his duty at common law; he is not required as a matter of prison practice to feed a prisoner artificially against the prisoner's will. […] I am advised that the common law duty placed upon a person in charge of a prisoner is to take such steps as are reasonable in the circumstances of each case to preserve the health and the life of the prisoner. In making their decision in respect of any particular case they must have regard not merely to the dangers likely to flow from the prisoner's refusal of food, but also to those likely to flow from the practice of forced feeding itself, if it is resorted to, and particularly if it is resisted.
>
> Accordingly, the future practice should, in my view, be that if a prisoner persists in refusing to accept any form of nourishment, the medical officer should first satisfy himself that the prisoner's capacity for rational judgement is unimpaired

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195 BMA 1992, p. 123.

196 As cited by Zellick 1976, p. 153. He furthermore notes that for a long time force-feeding was not regarded a ministerial responsibility. Prison Standing Orders (confidential directives prepared by the Prison Department at the Home Office which were distributed throughout the prison system) required that notice was to be given to the Home Office when force-feeding began and ended. Until 1974, however, no Home Secretary had been consulted about such matters. Zellick 1976, pp. 154-155.

> by illness, mental or physical. If the medical officer is so satisfied he should seek confirmation of his opinion from an outside consultant. If the consultant confirms the opinion of the prison medical officer, the prisoner should be told that he will continue to receive medical supervision and advice and that food will be made available for him.
>
> He should be informed that he will be removed to the prison hospital if and when this is considered appropriate. But it should be made clear to him that there is no rule of prison practice which requires the prison medical officer to resort to artificial feeding (whether by tube or intravenously). Finally, he should be plainly and categorically warned that the consequent and inevitable deterioration in his health may be allowed to continue without medical intervention, unless he specifically requests it."

This passage shows that the Home Secretary acknowledged the dangers of not only the hunger strike, but also the dangers of force-feeding, particularly when the prisoner resists. He stressed the importance of capacity for rational judgment (i.e. competence), and its assessment. Furthermore, the prisoner should be informed about a possible transfer to the prison hospital, and that his decision to go on hunger strike may have severe health consequences, as no rule of prison practice requires that his health will be preserved by means of force-feeding.

But above all, Jenkins in this passage clearly emphasises future prison practice, i.e. that the prison physician is not required as a matter of course to feed a prisoner against his will. Still, he does not go as far as forbidding force-feeding. The prison physician can still decide to apply feeding to a prisoner on hunger strike, if this is medically necessary to preserve the prisoner's life. When taking this decision, he must have due regard to not only the danger of the prisoner's food refusal, but also to the medical risks of the force-feeding itself. The prison physician is, however, strictly bound by the competent prisoner's wishes, as I will elaborate on later. In deciding on force-feeding, no other interests than the patient's must play a role. This marks a difference in policy before 1974, in which the political dimension of hunger strikes played a significant role in considering force-feeding.

After announcing the new policy, Jenkins noted that his desire was to make the position clear, and concluded by stating that "Perhaps the best way to sum it up is that I hope that in future a medical officer confronted with a prisoner who is on hunger strike will treat him in the prison as nearly as possible in the way in which a doctor would treat a free man or woman outside prison".[197] Home Secretary Jenkins also noted that he had discussed this subject with the Secretaries of State for Scotland and Northern Ireland, who decided that this policy will also apply in Scotland and Northern Ireland. This statement meant a breach with the longstanding

[197] As cited by Zellick 1976, p. 176.

UK prison policy of feeding hunger strikers against their will, and has remained consistent policy until now.

What were the reasons behind this change? Zellick, in his article, identifies two factors behind the growth in disapproval of force-feeding practices, that in his opinion led to the 1974 change in policy. First of all, public opinion grew disapproving of force-feeding practices, perhaps on learning the details of the exercise that were revealed in the press. In June 1974, an opinion poll by the Opinion Research Centre showed that 71 per cent of the sample thought that prisoners should not be force-fed.[198] It remains unclear in my opinion, however, if this outcome was caused by the aversion to force-feeding practices by the general public or was based on hostility towards the IRA prisoners then on hunger strike and a desire not to be dismayed by the prospect of their imminent death, similar to surveys in response to the RAF hunger strikes in Germany in the 1970s (see § 3.4 of this chapter). Secondly, according to Zellick, there was the acknowledgement by the medical profession that the practice of force-feeding was not free from risks, which was demonstrated by the reserved attitude of physicians to force-feeding in the case of a young Irish hunger striker Michael Gaughan. After prolonged force-feeding by tube, Gaughan continued his resistance, which made continued intervention dangerous, and the prison doctors ceased further intervention.[199] Force-feeding was similarly stopped in the case of the Price sisters. According to Zellick, these cases reflected a change in the attitude on the part of the prison doctors.[200]

I agree with Zellick that the growing opposition of the medical profession influenced the change in policy, moving away from force-feeding. During the force-feeding of hunger striking suffragettes (on which I elaborated in the previous section) physicians already voiced their opposition to force-feeding. Similar medical protests were manifested in 1974 and gained momentum. In June 1974, Maurice Moor, on behalf of the Joint Action Committee – a group campaigning on behalf the four hunger strikers in Brixton prison, including the Price sisters – revealed in a letter to the *Lancet* that the doctor carrying out the force-feeding had stated that he had no desire to force-feed the Price sisters, but that he was solely carrying out the orders of the Home Office. This was contrary to the statement of the Home Office that force-feeding was carried out, not under their orders, but only following the judgment of the prison's medical officers. In his letter, Moore asked the BMA to make a stand on this issue.[201]

The BMA debated the issue of force-feeding prisoners on hunger strike intensively in 1974 and 1975. A position was taken by the BMA Central Ethical Committee in their statement as published in the *British Medical Journal* on 6 July 1974, eleven

198 Zellick 1976, p. 156.

199 Gaughan died of pneumonia of malnutrition as a result of his hunger strike.

200 Zellick 1976, pp. 156-159.

201 Moore 1974, p. 1109.

days before Jenkins' statement on force-feeding.[202] In their opinion, the help to a prisoner on hunger strike may take several forms, and must always include an explanation to the prisoner of the effects of self-starvation upon his health, but on rare occasions "the desirability of artificial feeding will have to be considered". In this statement, the BMA Central Ethical Committee did not condemn force-feeding as unethical or qualify it as torture, but referred to the physician's obligation to preserve human life. It is for the individual physician to decide on force-feeding, and "[i]n this procedure a prison medical officer must be given complete clinical independence in deciding for or against the course of action under consideration." Accordingly, "the final decision must be for him [the prison medical officer] to make, and it is not for some outside person to seek to override the clinical judgement of the doctor by imposing his own decision upon the case in question". In the BMA Central Ethical Committee's statement it is furthermore noted that the President of the General Medical Council had stated that in his personal opinion that the participation by a physician in force-feeding, provided that such procedures were lawful and designed to preserve a prisoner's health, would not be considered serious professional misconduct. The BMA Central Ethical Committee, in this way, leaves a wide degree of interpretation for the treating physician, who may also decide to apply force-feeding in a specific case.[203]

Several months after Jenkins' statement on force-feeding prisoners on hunger strike, in April 1975, the BMA issued a statement published in the *British Medical Journal* in which it further provided clarification for physicians on "medical aspects of interrogation and of artificial feeding of prisoners". In this document, it cited the statement of the BMA Central Ethical Committee's policy on hunger strikes, but also integrally cited the new policy as announced by Home Secretary Jenkins.[204] In this statement, the BMA furthermore emphasised that "opposition to the political regime in any country must *not* automatically be equated with mental disorder, and this distinction must always be borne in mind" and "at least one doctor other than the prison medical officer must confirm that the prisoner's capacity for rational judgement is unimpaired by illness, mental or physical".[205]

In these two statements, the BMA did not explicitly condemn force-feeding in competent prisoners. The reserved and cautious attitude in the 1974 BMA Central Ethical Committee's statement, in my opinion, can be explained by the timing of its appearance, eleven days before the announced statement by the new Home

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202 "Ethical Statement. Artificial Feeding of Prisoners", 6 July 1974, *British Medical Journal* 1974, p. 52. This statement was adopted during the BMA's 1974 Annual Representatives Meeting,

203 Ibid.

204 "Statement by the BMA upon the medical aspects of interrogation and of artificial feeding of prisoners", January 1975, *British Medical Journal* 26 April 1975, pp. 229-230.

205 Ibid., p. 230.

Secretary, awaiting his view on this point.[206] Still, in the BMA's April 1975 statement (thus after Jenkins' statement on the new government policy on force-feeding) again no such explicit prohibition was included, limiting itself to referring to the Home Secretary's statement. In my opinion, this is remarkable, especially considering the fact the BMA has been one of the driving forces behind the creation of the 1975 WMA Declaration of Tokyo, holding that prisoners capable of forming a rational judgment about the consequences of hunger strike and holding that they should not be artificially fed without consent (Article 5 of the 1975 Declaration of Tokyo, after the 2006 revision Article 6, see Ch. 5, § 2.2.1); an article strongly resembling the Home Secretary's 1974 statement. Although in my view a statement that force-feeding in competent prisoners is prohibited is lacking in the 1975 BMA's statement on medical involvement in hunger strikes, Julian C. Sheather, then senior ethics adviser with the BMA, stated in October 2005:

> "The British Medical Association has established policy, dating back as far as 1974, which states unequivocally that prisoners capable of forming a rational judgement about the consequences of a hunger strike should not be fed artificially without their consent. Where it is clear that detainees intend to continue the strike until death, their refusal must be respected after they lose capacity and they must be allowed to die with dignity."[207]

In his opinion, a prohibition of force-feeding competent prisoners on hunger strike can in fact be read into the 1975 BMA statement upon the medical aspects of interrogation and of artificial feeding of prisoners.

In my opinion, it was not until 1993 that the BMA explicitly spoke out against force-feeding in competent hunger strikers. In the 1993 BMA publication *Medical Ethics Today*, the BMA explicitly adopted the policy as formulated in the WMA's Declaration of Tokyo, stating that "[o]n the question of the artificial feeding of prisoners on hunger strike, the BMA supports the World Medical Association's Declaration of Tokyo, which states that when prisoners refuse nourishment and are considered by the doctor to be capable of forming an unimpaired judgement, they shall not be fed artificially".[208] The BMA furthermore recommended that prisoners be clearly informed in advance of the doctor's policy concerning resuscitation during hunger strike. The only reason to apply artificial feeding, in the opinion of the BMA, is if the doctor has any doubts about the prisoner's intention, or when he is asked to treat an unconscious prisoner whose wishes cannot be ascertained. The

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206 This argument is supported by the last phrase in the BMA Central Ethical Committee's statement: "The Association welcomes the statement made by the Home Secretary in the House of Commons on 23 May 1974 that he is considering the broader implications of this subject, and it would be glad to assist him in any way".

207 Sheather 2005.

208 BMA 1993, p. 22.

physician then must act in the best interests of the prisoner, which might involve resuscitating the hunger striker and artificially feeding him.[209]

In current policy, the BMA continues to leave decisions on force-feeding to the individual doctor, while drawing attention to the WMA declarations of Tokyo. Nowadays, the voluntary refusal of treatment by competent and informed patients is still respected as a matter of principle. In the words of the BMA: "[w]hen it is clear that detainees intend to continue the strike until death, they must be allowed to die with dignity".[210]

How can this evolution in policy concerning hunger strikes in the UK be explained? I agree with Zellick that the moving away from force-feeding in government policy on hunger strikes was strongly influenced by the growing resistance by physicians to force-feeding hunger strikers. This development, in my opinion, took place behind an evolution in medical ethics away from paternalism towards absolute respect for patient autonomy, culminating in the acknowledgement in the doctor-patient relationship of an absolute right to refuse medical treatment. This right to refuse medical treatment was developed in non-custodial patient relationships, but was rapidly analogously extended to doctor-patient relationships in prison. The policy as announced by Jenkins in 1974 is still the current policy on hunger strikes in England and Wales: prisoners on hunger strike are treated in the same way as they would be treated in the outside world. As stated in § 3.2 of this chapter, in the 1984 case of *Freeman v Home Office* it was acknowledged that a prisoner is as capable as any other person of giving consent to medical treatment, and current government policy shows that no competent prisoners can be treated against his will. The same goes for respect for living wills: just as with persons in the outside world, prisoners' living wills are respect, as they form an expression of patients' wishes when they were still competent.

Legally, the way towards respect for the patient's right to refuse medical treatment was paved by an alteration in the attitude towards suicide. For a long time, hunger strikes were thought of as a form of suicide, which was a criminal offence.[211] Force-feeding by the prison authorities was justified as being necessary to prevent a criminal offence (a prison suicide) from occurring. In 1961, however, the Suicide Act abrogated the offences of suicide and attempted suicide.[212] From that moment, force-feeding could no longer be justified in hunger strikes in order to prevent a

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209 Ibid.

210 BMA 2004, p. 625.

211 See, for example, Moxey 1872, who qualified feeding of hunger strikers as "[f]eeding by the nose in *attempted suicide by starvation* [emphasis added]". Also during the suffragette hunger strikes, these hunger strikers were described by the then Home Secretary McKenna as prisoners who were "*attempting, or committing, suicide by starvation* or from injuring their health and strength by declining nourishment [emphasis added]". Cited by Savill, Moullin & Horsley 1912–3.

212 Still, it retained the offence of aiding, abetting, counselling or procuring suicide.

criminal offence. In 1995, in the case of *R v Home Secretary, ex parte Robb* (as will be discussed in the next section), it was furthermore acknowledged that death resulting from a refusal of treatment cannot be considered a suicide. Accordingly, death as a result of a hunger strike is not an act of suicide, but the ultimate result of a refusal of treatment. A physician who complies with a patient's wishes in such a case neither aids nor abets a suicide.[213]

The new approach towards hunger strikes and force-feeding as announced by the Home Secretary in 1974 was demonstrated in the Maze prison in Northern Ireland in 1980 and 1981. In these hunger strikes, the wishes of the hunger strikers were respected and no force-feeding was applied. Doctors provided advice and supervision, but did not go against the prisoner's clearly expressed wishes not to be force-fed. The British government did not concede to the hunger strikers' demands. As a result, ten prisoners eventually died as a result of their actions, the first of which IRA prisoner Bobby Sands, who became an Irish Republican martyr as a result.[214] Although this hunger strike demonstrated a pretty severe stress-test for the new policy, as the hunger strike proved a threat to order and security in the prison and was highly politically charged, the British government showed resilience in the treatment of hunger strikes as announced in 1974. This demonstrated the strong recognition of the prisoner's right to refuse treatment; a principle that is upheld even under very difficult circumstances.

4.6. THE CASE OF *R v HOME SECRETARY, EX PARTE ROBB*

For a long time, the case of *Leigh v Gladstone* formed the legal basis of force-feeding prisoners on hunger strike, and provided the only case law on hunger strike. This changed in 1995, with the case of *R v Home Secretary, ex parte Robb*.[215] The

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213 *R v Home Secretary, ex parte Robb* [1995] 1 All ER 677, referring *to Airedale NHS Trust v Bland* [1993] 1 All ER 821 [1993] AC 789. In this latter case, the health authority responsible for a 21-year-old patient in a persistent vegetative state applied to the court for declarations that the responsible physicians could lawfully discontinue all life-sustaining treatment and medical support designed to keep the patient alive. Here, the House of Lords held that "discontinuance of life support by the withdrawal of artificial feeding or other means of support did not amount to a criminal act because if the continuance of an intrusive life support system was not in the patient's best interests the doctor was no longer under a duty to maintain the patient's life but was simply allowing his patient to die of his pre-existing condition and his death would be regarded in law as exclusively caused by the injury or disease to which his condition was attributable." In conclusion, the physician was allowed to leave the patient to die, and the discontinuance of life support and further medical treatment did not amount to a criminal act, because his death was regarded in law as purely caused by the disease the patient was suffering from. This differs from euthanasia, in which a physician actively takes steps to end his patient's life, which also qualifies a criminal act under British law.

214 For an account of these events, see Ryder 2000 and O'Malley 1990.

215 *R v Home Secretary, ex parte Robb* [1995] 1 All ER 677.

27-year-old prisoner Robb who had been diagnosed as suffering from a personality disorder, went on hunger strike in August 1994. Despite the prisoner's addiction to heroin, history of self-injury and personality disorder, medical experts diagnosed that Robb was of sound mind and understanding, and he was advised of the clinical consequences of his decision. The Home Secretary sought declarations that the Home Office, prison officials and the physicians and nursing staff responsible for the prisoner 1) might lawfully observe and abide to his wishes to refuse food, and 2) might lawfully abstain from providing him with hydration and nutrition (by artificial means or otherwise), for so long as he retained the capacity to refuse it. Thorpe J. stated that

> "[t]he first principle is that every person's body is inviolate and proof against any form of physical molestation. […] Secondly, the principle of self-determination requires that respect must be given to the wishes of the patient. So if an adult of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes even though they do not consider it to be in his best interest to do so."

Thorpe J. found authority for this principle in the 1993 cases *Re T (Adult: Refusal of Treatment)* and *Airedale NHS Trust v Bland.*[216] In the case of *R v Home Secretary, ex parte Robb*, the High Court granted the Home Office the declarations sought. It held that the right of an adult of sound mind to self-determination prevailed over any countervailing interest of the State. As a result, the Home Office, prison officials and the physicians and nursing staff responsible for the care of a prisoner of sound mind who went on hunger strike could lawfully observe and abide by this refusal to receive nutrition and could lawfully abstain from providing hydration and nutrition (by artificial means or otherwise), for so long as he retained the capacity to refuse it. Since, in this case, prisoner Robb was of sound mind and understanding, and there was no evidence to rebut the presumption of his capacity to decide to refuse nutrition and hydration, the Home Secretary was under no duty to force-feed the prisoner to prolong his life.

The change in policy in the case of *R v Home Secretary, ex parte Robb*, compared to the *Leigh v Gladstone* ruling is obvious. Although in 1984, in the case of *X v Germany*, the EComHR upheld the obligation to intervene in case of an obvious threat to the hunger striker's life under German law by holding that a decision to force-feed a prisoner on hunger strike with a view to securing his survival was acceptable,[217] the case of *R v Home Secretary, ex parte Robb* shows that this approach

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[216] *Re T (Adult: Refusal of Treatment)* [1993] Fam 95 (see § 4.2 of this chapter) and *Airedale NHS Trust v Bland* [1993] 1 All ER 821 [1993] AC 789.

[217] EComHR 9 May 1984, *X v Germany*, App. No. 10565/83, 7 E.H.R.R. 135, p. 154. See for an elaboration on this case Ch. 5, § 3.4.3.

was not followed in the UK. Unlike in 1909, in the case of *R v Home Secretary, ex parte Robb* it was clearly held that the principles of bodily inviolability and self-determination took precedence over any possible countervailing State interest and the prison authorities could lawfully abstain from intervention. Thorpe J. explicitly referred to the case of *Leigh v Gladstone* and considered this ruling as a product of its time, noting "[i]t was a decision taken in the climate of dramatic conflict between the suffragette movement and the government of the day. The point does not seem to have been fully argued and the charge to the jury of Lord Alverstone CJ is of little relevance or weight in modern times in determining the current law." Thorpe J. considered the *Leigh v Gladstone* no longer to be of contemporary relevance: "[f]or many reasons it seems to me that that authority is of no surviving application and can be consigned to the archives of legal history". With this, the High Court explicitly dismissed the legal basis for the force-feeding of suffragettes as formulated in the 1909 case of *Leigh v Gladstone* and upheld the new policy on hunger strike as announced by the Home Secretary in 1974.

Another interesting aspect of the case of *R v Home Secretary, ex parte Robb*, is that Thorpe J. goes into developments in other common law jurisdictions, particularly the US, with regard to hunger strikes and the right to refuse food. In several US cases,[218] it was held that the right to self-determination of a hunger striker is not absolute, and that there were four specific State interests that might countervail: 1) preserving life, 2) preventing suicide, 3) maintaining the integrity of the medical profession, and 4) protecting innocent third parties. Thorpe J. goes in each of these State interests separately, and assesses their relevance to this case.

With regard to the first interest, Thorpe J. notes that the State's interest in preserving life is part and parcel of the balance that must be struck in determining and declaring the right to self-determination, in which "the sanctity of human life in this jurisdiction is seen to yield the principle of self-determination". Secondly, the interest of preventing suicide has no application in cases such as this where the refusal of nutrition and medical treatment in the exercise of self-determination does not constitute an act of suicide. Thirdly, he notes that medical-ethical decisions can be acutely difficult and at their most acute they can be brought to the High Court for declaratory relief, and adds that "I cannot myself see that this is a distinct consideration that requires to be set against the right of self-determination of the individual". Fourthly, he notes that the consideration of protecting innocent third parties is "one that is undoubtedly recognised in this jurisdiction", and refers to the case of *Re S (Adult: Refusal of Medical Treatment)*, a case in which it was held that an emergency Caesarean section could be carried out upon a patient contrary to her beliefs because the operation was vital to protect the life of the unborn child.[219] He furthermore notes that the further interest of preserving the internal order,

[218] Especially *Thor v Superior Court* (1993) 5 Cal. 4th 725, Cal SC.

[219] *Re S (Adult: Refusal of Medical Treatment)* [1992] 4 All ER 671.

discipline and security within the confines of the jail can also play a role in English law as a countervailing State interest to be balanced against the individual's right to self-determination. Thorpe J. concludes by stating that "neither of these considerations arise in the present case". Accordingly, he only briefly mentions them, and states that "[i]t seems to me that within this jurisdiction there is perhaps a stronger emphasis on the right of the individual's self-determination when balance comes to be struck between that right and any countervailing interests of the state" and concludes that this case is not a borderline one and constitutes a plain case for declaratory relief.

In Thorpe J.'s view, it is highly doubtful that any of those countervailing interest would overrule the prisoner's right to self-determination in case of hunger strike. Still, he does not elaborate on this, because neither of these interests was advanced in this case.

4.7. NO OBLIGATION, BUT A RIGHT TO FORCE-FEED?

In some commentaries, it has been noted that in the ruling of *R v Home Secretary, ex parte Robb*, Thorpe J. stated that the defendant *may* abide by the plaintiff's decision and *may* abstain from providing food and water; he does not say that they *must* abide by the prisoner's decision. Accordingly, the thrust of the judgment is permissive rather than obligatory. Obviously, there is no obligation for the prison authorities to intervene in the hunger strike. But Kennedy has noted that this raises the question of whether there remains the *power* to intervene in a hunger strike through force-feeding, a question that is not resolved by the ruling itself.[220]

This discussion was also brought up in the 2000 case of *R v Collins, ex parte Brady* (as will be discussed in the next section).[221] Maurice Kay J. considered what would happen if Brady had capacity, but was detained in hospital for medical treatment for mental illness or disorder. He considered the case of *R v Home Secretary, ex parte Robb* in relation to the case of *Reeves v Commissioner of Police*, in which it was determined that the police and prison authorities owe a duty under common law to take reasonable care to prevent prisoners from committing suicide.[222] Maurice Kay J. notes, in this respect, that it "would be somewhat odd if there is a duty to prevent suicide by an act (for example the use of a knife left in a cell), but not even a power to intervene to prevent self-destruction by starvation". As Williams correctly notes, in this respect Maurice Kay J's observations fail to distinguish between suicide in prison and hunger-striking.[223] In the case of *R v Home Secretary, ex parte Robb*, five years earlier, it was acknowledged that death resulting from a refusal of treatment

220 Kennedy 1995, p. 191.

221 *R v Collins, ex parte Brady* [2000] Lloyd's Rep Med 355.

222 *Reeves v Commissioner of Police of the Metropolis* [1999] 3 WLR 363.

223 Williams 2001, p. 290.

cannot be considered suicide. Accordingly, death as a result of a hunger strike is not an act of suicide, but the ultimate result of a refusal of treatment. In this way, his reasoning does not hold water.

Maurice Kay J's reasoning, however, did not lead to the conclusion that Brady could be force-fed. With respect to the facts of the case that were brought up in *R v Collins, ex parte Brady,* Maurice Kay J. noted that in this case (as in the case of *R v Home Secretary, ex parte Robb*) no third parties' interests were advanced that required adjudication. For this reason, he noted "that it would be unwise for me to make a finding in this issue", and he acknowledged that "[i]t is a complex matter and, because the case was prepared primarily with the preceding issues in mind, I do not consider that there is before me all the evidence with which to make definitive decision". Still, in an *obiter dictum* he goes as far as expressing view on the matter, stating that

> "It would be a disappointment to me if I were constrained by authority from finding in favour of the respondents on this issue. My impression is that I would not be. Moreover, it would seem to me to be a matter for deep regret if the law has developed to a point in this area where the rights of a patient count for everything and other ethical values and institutional integrity count for nothing."

Accordingly, Maurice Kay J. seemed to be of the opinion that third parties' interests may overrule a self-determined hunger strike and that these interests may enable intervention, while Thorpe J. was far more doubtful on the question of whether a countervailing interest could overrule the prisoner's right to self-determination in case of hunger strike. This raises an interesting point.

In the case of *R v Home Secretary, ex parte Robb* only the question of whether a duty to intervene existed was addressed, and the question of whether there is a power to intervene was not. The use of the word *may* in the case of *R v Home Secretary, ex parte Robb*, in my opinion, might be strongly influenced by the way the declaration sought is phrased: they sought declarations that they *might* lawfully observe and abide by the respondent's refusal to receive nutrition, and that they *might* lawfully abstain from providing him with hydration and nutrition and so on, to which the answer is "yes, they may". Still, the fundamental question remains of whether third parties' interests may lead to overrule the prisoner's right to self-determination and justify intervention. In the literature, opinions differ on this matter. Kennedy, for example, seems to be of the opinion that, on the basis of *R v Home Secretary, ex parte Robb* the prison authorities are not denied the power to intervene.[224] Mason and Laurie also find that there are "recognizable situations in which the communitarian ethos supersedes that of personal autonomy", still they only conclude so for mentally disordered prisoners: "[t]here is indeed, some

[224] Kennedy 1995.

evidence that judicial opinion is turning away from an absolute adherence to the principle of respect to autonomy as applied to the *mentally disordered* [emphasis added]."[225] By contrast, Williams notes that in *R v Governor of HMP Frankland ex parte Russsel and Wharrie* (1999) Lightman J. considered *R v Home Secretary, ex parte Robb* to be clear authority for the proposition "that the Governor has no *right* or duty to force-feed prisoners on hunger strike [emphasis added]".[226] This statement, again, was done in an *obiter dictum*. Still, it shows that opinions on this matter differ, not only in the literature, but also among judges – here Maurice Kay J. and Lightman. Concluding, there is obviously no obligation to force-feed prisoners on hunger strike (this was also stated in no uncertain terms in the 1974 statement by Jenkins), but the question of whether a right to force-feed prisoners on hunger strike exists remains controversial.

Although I acknowledge that in English law, the current view adheres to the idea of respect for the prisoner's self-determination in almost absolute form, the legitimacy of force-feeding of a prisoner on hunger strike remains to be decided upon on a case-by-case basis, and the above-mentioned opinions of the judges involved in these two cases show that third parties' interests can in fact play a role and – in my opinion – could even carry much weight in deciding on force-feeding. I will elaborate on the interests that can overrule the prisoner's right to self-determination and the relation to the situation in England and Wales in Ch. 7, § 5.3.3.

4.8. THE CASE OF *R v COLLINS, EX PARTE BRADY*

The case of *R v Home Secretary, ex parte Robb* provided clarification on the question of forced medical treatment in competent prisoners. It was stated that the Home Secretary was under no duty to order force-feeding of the prisoner to prolong the competent prisoner's life. A special assessment framework for the use of force-feeding in prisoners applies for incompetent prisoners under the Mental Health Act 1983, as the case of *R v Collins, ex parte Brady* shows.[227]

The claimant in the latter case, Ian Brady, was serving three sentences for murder. After being moved to another ward in Ashworth Hospital on 30 September 1999, he went on hunger strike.[228] On 29 October a decision was taken to start force-feeding by way of nasogastric tube. By way of proceedings for judicial review the applicant challenged the decision of the respondents to force-feed him. The applicant

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225 Mason & Laurie 2011, p. 437.

226 Williams 2001, p. 290, referring to *R v Governor of HMP Frankland ex parte Andrew Russell and Perry Wharrie* (2000) QBD (Crown Offce List).

227 *R v Collins, ex parte Brady* [2000] Lloyd's Rep Med 355.

228 In the ruling, Brady's actions were qualified as a "hunger strike", but in the definition as used in this research because of his incompetence, his actions would merely be regarded as a food refusal.

contended that his refusal of food was related to his mental disorder and was a rational decision by a competent person. He further contended that force-feeding was not justified under Section 63 of the Mental Health Act 1983 because it was not medical treatment given to him for the mental disorder from which he was suffering.[229] Maurice Kay J. dismissed the application, holding that the decision to commence and continue force-feeding was justified on the basis of Section 63 of the Mental Health Act 1983 and that it was and is in all respects lawful, rational and fair. The hunger strike, he considered, was a manifestation or symptom of the applicant's personality disorder, and in this way force-feeding constituted necessary medical treatment for his underlying mental disorder, within the meaning of Section 63 of the Mental Health Act 1983. He added that if even if this case was considered outside Section 63, the force-feeding would still have been lawful by reason of the fact that "the applicant has at all material times lacked capacity by reason of his disorder and the steps taken by the doctors have been lawfully taken in what they have lawfully and reasonably to be in his best interests".[230]

In this way, Section 63 of the Mental Health Act 1983 provides extended possibilities for the use of force-feeding on a prisoner who refuses food, when force-feeding qualifies as medical treatment for the treatment of the mental disorder from which he is suffering.

4.9. CURRENT POLICY ON HUNGER STRIKE IN PRISON AND GUIDANCE BY THE DEPARTMENT OF HEALTH

When the cases of prisoners Robb and Brady are compared, it can be concluded that when a competent hunger striker decides to refuse medical treatment, this decision has to be respected, and he cannot be treated against his will. The role of the physician is to advise him of the consequences of his decision and the dangers of starvation, and to provide medical care to the hunger striker, and in prolonged hunger strikes to provide palliative care. If a prisoner lacks capacity to decide on his food refusal, by contrast, there are possibilities to overrule the prisoner's right to self-determination, and the physician must act in the best interests of the patient, which may include force-feeding. Furthermore, intervention through the

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229 Section 63 of the Mental Health Act 1983 determines that "[t]he consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering […] if the treatment is given by or under the direction of the approved clinician in charge of the treatment".

230 In *B v Croydon Health Authority* [1995] 1 All ER 683 (a case concerning a patient compulsorily detained under Section 3 of the Mental Health Act 1983 with a borderline personality disorder potentially needed force-feeding), the Court answered the question of whether force-feeding by a nasogastric tube can constitute medical treatment within the meaning of Section 63 of the Mental Health Act 1983 in a positive sense.

use of force-feeding may take place on the basis of Article 63 of the Mental Health Act 1983, but only if the force-feeding is necessary to treat the underlying mental disorder from which he is suffering. In this way, the determination of capacity and competence is crucial.

In 2002, the Department of Health published a booklet for prison health care staff to provide guidance on the issue of seeking consent form people in prison, entitled *Seeking Consent: Working with People in Prison*. In this booklet, there is a part on food refusal, summarising the legal framework as developed in case law.[231] In January 2010, a document entitled *Guidelines for the Clinical Management of People Refusing Food in Immigration Removal Centres and Prisons* was published by the Department of Health, elaborating on the issue of hunger strike and food refusal in prison.[232] This document provides health professionals in prisons and removal centres with information on the physical effects of food refusal, the practical and clinical management of hunger and thirst strikers, procedures for refeeding, legal aspects and the relevance of the Mental Capacity Act 2005. As the guidelines note, guidance on the right to refuse food and/or treatment was previously specific to prisons, but the Mental Capacity Act 2005 made guidance applicable to all settings. Accordingly, "[a]ny individual has the legal right to refuse food and fluid".[233] In my opinion, this document is a valuable source of information for those involved in the clinical management of hunger strikers, as it gives detailed direction on the medical and legal aspects involved in the treatment of hunger strikers.

4.10. DEATH AS RESULT OF A HUNGER STRIKE

Nowadays, prison hunger strikes are rare in the UK. As in Germany, there are much fewer political prisoners, and hunger strike only rarely occurs in individual cases. Still, the ultimate consequence of a policy in which prisoners and detainees have the legal right to refuse to eat and drink, is the death of a prisoner on hunger

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231 Department of Health, *Seeking Consent: Working with People in Prison,* 5 July 2002, under 6.3-6.7, available at <http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4034353.pdf> (last accessed on 3 February 2012). The Department of Health guidance *Reference Guide to Consent for Examination or Treatment*, d.d. August 2009 (second edition) gives fuller guidance on the issue of consent, although not specifically directed to prisons it is also applicable there. This reference guide also includes a part on food refusal and force-feeding, under 52. For people working in Wales the Welsh Assembly has published its own version of the *Reference Guide to Consent for Examination and Treatment* in April 2002, which, however, does not contain a separate part on food refusal and force-feeding.

232 *Guidelines for the Clinical Management of People Refusing Food in Immigration Removal Centres and Prisons*, Department of Health. This document can be found at <http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_104769> (last accessed on 3 February 2012).

233 Ibid., p. 1.

strike. In recent history, death as a result of a hunger strike is extremely rare. The Prisons and Probation Ombudsman for England and Wales, (the organisation that not only investigates complaints from prisoners, those on probation and those held in immigration removal centres, but also investigates all deaths that occur among prisoners, immigration detainees and the residents of probation hostels) noted in its Annual Report 2009-2010 that "[d]eaths in England and Wales of prisoners who decide to stop taking food are fortunately rare, although the possible long-term effects of nutritional deprivation should not be underestimated". In the first five years that the Ombudsman's office was responsible for investigating deaths in custody, only one death directly attributed to food refusal was reported.[234] In 2009, however, there have been two more deaths from such causes. These are the deaths of 54-year-old prisoner John Dabrowski serving an indeterminate sentence for public protection (IPP) who starved himself to death at Stafford jail in January 2009[235] and 77-year-old prisoner Ronnie Easterbrook who died after a prolonged hunger strike in Gartree prison a couple of months later on 10 May 2009.[236] These deaths were investigated by the Prisons and Probation Ombudsman, and the report on the death of John Dabrowski was published in March 2010.[237] In this report, the Prisons and Probation Ombudsman stated that

> "[t]his report reflects upon sad and traumatic events for all those involved. Both staff and prisoners could see what was happening to the man but were unable, legally, to intervene. The best that staff could do was to manage the situation and make the man as comfortable as possible. It is a credit to the Governor and his staff that they managed to achieve this with compassion and professionalism."[238]

Accordingly, no further recommendations were made.

Although hunger strikes by prisoners are rare, hunger strikes by detainees in holding centres are far more common. Although precise numbers are lacking, Dr Frank Arnold, physician with Medical Justice, recalls at least 36 hunger strikes in

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234 Prisons and Probation Ombudsman for England and Wales, Annual Report 2009-2010, pp. 23-24. The one death referred to was the death of a man who died in February 2006 hospital whilst on remand at HMP Lincoln for the murder of his daughter. The report by the Prisons and Probation Ombudsman for England and Wales on this death was published in March 2008. All reports by the Prisons and Probation Ombudsman can be found on its website <http://www.ppo.gov.uk/> (last accessed on 21 February 2012).

235 *This is Staffordshire* 19 January 2009.

236 Allison 2009.

237 "Investigation into the circumstances surrounding the death of a man at the Samuel Johnson hospital whilst in the custody of HMP Stafford in January 2009", Report by the Prisons and Probation Ombudsman for England and Wales, March 2010.

238 Ibid., p. 2.

immigration centres during the past five years.[239] According to the BMA, principles for the management of hunger strikes remain the same in each setting (prison, remand centre and holding centre for people facing detention)[240] which is also reflected in the above-mentioned 2010 guidelines as issued by the Department of Health, which applies to both prisons and removal centres.

4.11. CONCLUSIONS

From on the early twentieth century, suffragettes in several British prisons were force-fed whilst on hunger strike. In the case of *Leigh v Gladstone*, these force-feeding practices were approved, emphasising the prison officials' duty to preserve the health and life of the prisoners in their custody. This approach towards hunger strikes was probably prompted by repressive government attitude towards the suffragette movement. For long time, force-feeding was used in prisoners on hunger strikes. This changed in 1974, when the Home Secretary announced future medical policy for the assessment and the management of hunger strikers in prisons, i.e. that the prison physician is not required as a matter of prison practice to feed a prisoner against his will.

Several reasons have been given for this drastic change in policy. In response to the growing debate in the medical profession, and the changed attitude as announced by the Home Secretary, the BMA issued two statements on force-feeding of prisoners, stating that the final decision must be for the prison medical officer to make, independent of other forces behind him. Although it can be doubted whether these statements condemn force-feeding in competent prisoners, the BMA was one of the driving forces behind the 1975 Declaration of Tokyo, which does contain such prohibition. In my opinion, growing opposition of the medical profession to the use of force-feeding was one of the most influential forces behind moving away from force-feeding in prisoners on hunger strike. Although medical protests were already voiced during the force-feeding of suffragettes, it was against the background in medical ethics that has developed away from paternalism towards absolute respect for patient autonomy that these protests in 1974 gained momentum. Furthermore, the abrogation of suicide as a criminal offence and the alteration in the attitude towards suicide have furthermore attributed to the recognising of the prisoner's right to refuse medical treatment and intervention. Also, from the end of the 1980s, case law was developed that acknowledged the inviolability of a person's body and the idea that the principle of self-determination required respect for the patient's wishes when competent, even when the proposed medical treatment was obviously in his best interests. These notions were rapidly extended to prisoners,

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239 Personal communication with Dr Frank Arnold, d.d. 24 May 2011.

240 BMA 2004, p. 623.

who accordingly must be treated in the same way as they would be treated in the outside world. Accordingly, a competent prisoner may not be treated against his will.

The legal precedent of *Leigh v Gladstone* was explicitly disapproved of in the 1995 case of *R v Home Secretary, ex parte Robb*, in which it was held that prison officials, physicians and nursing staff can lawfully observe and abide by the prisoner's food refusal and lawfully abstain from force-feeding. Although efforts must be made to persuade the hunger striker to start eating again, force-feeding in a competent hunger striker can be considered assault. The decision to refuse food can only be overruled when a prisoner refuses food as a result of a mental disorder under the Mental Health Act 1983 (as demonstrated in the case of *R v Collins, ex parte Brady*). In England and Wales, the question of the application of force-feeding nowadays is considered as a medical matter, dependent on a medical decision. In conclusion, in England and Wales, competent prisoners have the right to choose to refuse food and drink. If the prisoner has drawn up an advance directive in which he has stated his wish to refuse medical treatment until death supervenes, this advance directive has to be respected if the prisoner is no longer competent.

5. CONCLUSIONS

In the previous chapter it was demonstrated that the EComHR and the ECtHR have left much room to the Council of Europe Member States to create national policies on the issue of force-feeding prisoners on hunger strike. In this chapter I have investigated the question of the legitimacy of force-feeding in the jurisdictions of the Netherlands, Germany, and England and Wales.

It can be concluded that in all three investigated jurisdictions it is acknowledged that competent adult patients must consent before medical treatment may be performed. Minors from a certain age can also be required to consent to their medical treatment under certain circumstances. In all three jurisdictions investigated it is acknowledged that providing all relevant information with regard to the hunger strike to the hunger striker at all times is important, and medical assistance must be provided. On the question of whether intervention may be performed on a prisoner who refuses food and treatment, however, opinions differ in the three jurisdictions investigated, varying from absolute respect for the prisoner's decision to refuse food in England and Wales to a legal right to intervention on competent hunger strikers in Germany.

In England and Wales, prisoners on hunger strike must be treated in the same way as they would be treated in the outside world: a prisoner's right to self-determination is not more constrained than with any other patient. Accordingly, a competent prisoner may not be treated against his will, also not in a prolonged hunger strike, even if this decision may result in his death. Competent prisoners have the right to choose to refuse food and drink, and force-feeding is not allowed on such prisoners.

If a patient in England and Wales lacks competence, a physician will decide in what they lawfully and reasonably thinks to be in his best interests. In the Netherlands and Germany, for incompetent patients, consent of a legal representative is sought. In the Netherlands, similar to England and Wales no medical treatment is possible in competent patients. Still, on the basis of Article 32 PPA the prison governor has the possibility to oblige a prisoner to acquiesce to having a medical intervention carried out on him to avert serious risk to his health. The question of whether this Article can be applied in prolonged hunger strikes to justify the use of force-feeding became highly topical during the hunger strike of Volkert van der G. in 2002. Although this hunger strike has not officially altered the policy on hunger strike, the case shows how the policy that no force-feeding in competent prisoners is applied can be put under pressure. In Germany, the possibility for forced medical intervention in prisoners is created by Section 101 of the Enforcement of Punishments Act. This Section is explicitly applicable to force-feeding and was even created for this specific purpose. Pursuant to Section 101, in case of danger to life or serious danger to the prisoner's health, the authorities are under the obligation to intervene if the hunger striker does not act upon his own free will, while in the case of a hunger striker who is acting upon his own free will the authorities have a right to intervene in his hunger strike. Although current German policy seems to have shifted away from using force-feeding for competent prisoners' hunger strikes to respect the patient's wishes, the law still provides room to decide the opposite.

In Germany, it is widely acknowledged that not only the prisoner's own interests play a role in this decision, but that also third parties' interests can carry much weight in deciding on force-feeding. In fact, the creation and history of Section 101 of the Enforcement of Punishments Act was strongly influenced by the idea that third parties' interests, especially State interests, could outweigh respect for the prisoner's decision to refuse food. This dogmatic approach differs from the approach as illustrated in the Netherlands and England and Wales, in that both operate from the perspective of the prisoner and the basic principle that a prisoner's right to self-determination must be respected. The difference between the German dogmatic approach on the one hand and the more liberal approach of the Netherlands and England and Wales towards force-feeding in prisoners on hunger strike on the other hand is, in my opinion, strikingly reflected in the role of the living will, and the priority that is given to this document. In the Netherlands and England and Wales, a living will is a crucial document; if the hunger striker was competent when it was drafted, his wishes as laid down in this document have to be followed, even (and especially) if the hunger striker loses competence or lapses into a coma. In Germany, an obligation to intervene for the authorities exists to apply force-feeding in incompetent prisoners. A prisoner's living will, in this respect, is not automatically of much consequence; it will be balanced against other interests that may be involved, in which assessment of the prisoner's wishes as expressed in the living will may be outweighed by other State interests that argue in favour of force-feeding.

This difference in approach to the issue of hunger strike is in my opinion not only reflected in the role of the living will, but is also reflected in the terminology used in the literature to describe the principle rights involved in hunger strikes; where in the Netherlands and England and Wales in the literature "a right to hunger strike" for prisoners is mentioned,[241] in German literature "a right to intervene" for the State and its authorities is identified.[242]

Still, these contrasting views on force-feeding may not be so clear-cut as they appear at first glance. Although the Dutch approach is founded on the idea of respect for the prisoner's right to self-determination, in 2002, in Dutch politics it was argued that in assessing the application of Article 32 PPA to force-feeding, societal interests should play a role in deciding. This case demonstrated that while the discussion on the legitimacy of force-feeding seemed to be closed, exceptional circumstances brought about exceptions to the basic rule that no force-feeding is applied with competent hunger strikers. This view, as illustrated by the then Minister of Justice, however, has not been translated into new policy. In England and Wales, the application of force-feeding is a clinical treatment decision by the physician, which leaves no room for third parties' interests. Despite this, in the rulings of *R v Home Secretary, ex parte Robb* and *R v Collins, ex parte Brady* (and commentaries to these rulings) it can be noted that it is also acknowledged in England and Wales that third parties' interests can in fact play a role in deciding on force-feeding. When countervailing interests occur in a certain hunger strike, and the physician refuses to apply forced medical treatment to the hunger striker, the question of the use of force-feeding can be brought before the court. In the cases that have created legal precedent on the issue of force-feeding in hunger strikes (i.e. *R v Home Secretary, ex parte Robb* and *R v Collins, ex parte Brady*) no countervailing State interests were advanced.

In both the Netherlands and Germany, serious risk or danger to a prisoner's health is required before intervention is allowed. In England and Wales force-feeding is considered a medical matter, as a result it is the physician who decides if, and if so how and when, an intervention in the hunger strike is performed. That the assessment of the serious risk or danger to the prisoner's health requires a medical judgment is acknowledged in Dutch and German policy on hunger strikes. Still, unlike in England and Wales, in these jurisdictions it is not the physician who makes the final decision on whether force-feeding is applied or not, but the prison authorities who decide on this intervention, after having discussed the case with the physician. In the Netherlands, Article 32 PPA is directed to the prisoner involved: this stipulation determines that the prison governor may oblige a prisoner to acquiesce having a medical intervention carried out on him. In Germany, however, Section 101 of the Enforcement of Punishments Act is directly directed towards

241 See, for example, Kelk 2008, p. 289.

242 See, for example, Nöldeke & Weichbrodt 1981, p. 281.

the prison authorities: according to this stipulation, the prison authority is under the obligation or is entitled (depending on the mental condition of the prisoner) to intervene in a hunger strike through the use of force-feeding. Accordingly, in both jurisdictions it is the prison governor who carries responsibility for the decision to apply force-feeding in a certain case. A positive decision to apply force-feeding by the prison authorities in turn legitimises a physician to act against the patient's express wishes and to infringe upon his physical integrity. Although in the Netherlands the prisoner can be forced to undergo medical treatment, and in Germany the prison authorities can be forced to take a certain decision, the physician cannot be forced to perform force-feeding. If, and if so how, intervention is performed is left to him to decide.[243] If a physician refuses, however, the prison authorities may seek another physician who is prepared to perform the intervention.

Although the definitions used differ slightly in the three jurisdictions investigated, the element of competence can be considered to be the distinctive element in deciding on force-feeding. As stated above, in the Netherlands and England and Wales, a refusal of treatment by a hunger striker who is *compos mentis* must be respected, while such a decision can be overruled when made by a incompetent person. In Germany, incompetence leads to an *obligation* to intervene for the prison authorities if the hunger strike threatens his health or life, while in competent prisoners only a *right* to intervene exists in such situations. Accordingly, if the prisoner involved is declared to be incompetent, the patient's right to self-determination and his refusal of treatment can, or sometimes even must, be overruled. As a result, the assessment of competence is crucial in the question of the legitimacy of force-feeding in all three jurisdictions.

Comparing the development of policies on force-feeding prisoners on hunger strike in the three jurisdictions as discussed in this chapter, it can be noted that all these policies have been strongly determined by societal, legal and political developments in the country itself, and especially have been formed by experience with hunger strikes in the past. This is demonstrated by the influence of the suffragettes in Britain in the beginning of the twentieth century, and the RAF hunger strikes in Germany in the 1970s and 1980s, both of which created legal precedents and strongly shaped policies on force-feeding in the respective countries. Although having paved the way for national force-feeding practices (such as the 1984 case of *X v Germany*), the rulings of the EComHR and ECtHR do not have seem to have directly or strongly influenced policies on force-feeding in the Netherlands, Germany, or England and Wales, as national policies on force-feeding (especially in Germany and England and Wales) have been strongly grafted on national events.

Furthermore, experiences with hunger strikes in all three jurisdictions investigated show that collective and individual hunger strikes, especially when politically motivated, can severely challenge policy and the legal attitude to hunger strikes and

[243] Although this idea has been more widely acknowledged in the Netherlands than in Germany.

force-feeding. This was the case with the collective, long-term, repetitive and also fatal RAF hunger strikes in Germany, and the collectively employed IRA hunger strikes in the UK. Unlike similar experiences with such hunger strikes, Germany and England and Wales have demonstrated different attitudes to the phenomenon. The RAF prison hunger strikes led to the creation of Section 101 of the Enforcement of Punishments Act which, under certain circumstances, legitimised the application of force-feeding in both competent and incompetent prisoners on hunger strike. Subsequent cases of force-feeding in prisoners on hunger strike with fatal consequences led to the liberalisation of the obligation to force-feed competent prisoners on hunger strike, as demonstrated in the 1989 hunger strike by RAF prisoners. Currently, Section 101, and the right to intervene in prison hunger strikes seems to be maintained with an eye to future highly charged prison hunger strikes that severely challenge the prison system. Unlike the highly political RAF hunger strikes in Germany in the 1980s, similarly highly charged IRA hunger strikes did not induce a change in policy on force-feeding in England and Wales, but only demonstrated the new policy as announced by the Home Secretary in 1974. Not only collective, but also individual hunger strikes can have a disruptive effect on existing policies, as the 2002 case of Volkert van der G. in the Netherlands shows. This case also demonstrates that exceptional hunger strikes sometimes not only lead to the liberalisation of a State-focused approach to hunger strike, but can also conversely instigate the call for measures to intervene through force-feeding in jurisdictions with a liberal approach to force-feeding.

Another development that seems to have influenced policies on hunger strike in all jurisdictions investigated is the development of medical ethics, moving away from paternalism (the principle of *salus aegroti suprema lex*) to respect for patient autonomy (the principle of *voluntas aegroti suprema lex*). This development was, *inter alia*, reflected in the growing opposition by the medical profession to force-feeding practices, especially during the 1970s and 1980s as manifested as a reaction to the hunger strikes as occurring in Germany and England and Wales. This opposition has strongly influenced the creation and development of national force-feeding policies, most notably in the creation of policies that advocate absolute respect for patient autonomy, such as in England and Wales. In Germany, compared to the Netherlands and England and Wales, there is an overwhelming amount of legal literature on the issue of force-feeding, but strikingly little attention is paid to the medical-ethical aspects of force-feeding, and the WMA Declarations were for a long time conspicuous by their absence in the debate. This is not remarkable, since in the German dogmatic approach, State interests have played an important role, and these interests were long decisive in attitudes to force-feeding, while the Netherlands and England and Wales, policies have consistently focussed on the individual's right to self-determination.

CHAPTER SEVEN

SYNTHESIS

1. INTRODUCTION

As shown in the introduction to this book, hunger strikes are mostly used by those deprived of certain basic human freedoms, which applies literally to prisoners and detainees. In this research, the term "hunger strike" is defined as a determined effort by a mentally competent person who has indicated that he refuses food as a form of protest. In Ch. 1, § 2.5, I elaborated on the different elements of the definition. Only competent prisoners or detainees qualify as hunger strikers, as the definition indicates. Although a definition of competence is lacking, it is generally accepted that a patient who can clearly communicate his choice, understands the information about his condition, appreciates the consequences of his choices and can weigh the relative risks and benefits of the options, can be considered competent to make a decision on treatment. This study focuses on the specific situation of prisoners and detainees on hunger strike. In cases of prisoners and detainees on hunger strike, the dilemma between the responsibility of the State and the caretakers involved for the health of the hunger striker and other third parties' interest that may plead in favour of force-feeding, on the one hand, and the individual right to self-determination of the prisoner or detainee, derived from fundamental values as autonomy and human dignity, on the other hand, is most intense. A hunger strike can cause serious damage to the hunger striker's body and result in the hunger striker's death (see Chapter 1). Especially if the hunger strike is prolonged, the government, but also prison officials, physicians and nursing staff, can feel the urge – for a diversity of reasons explored in Chapter 4 – to intervene in the hunger strike through the use of force-feeding.

In this chapter, I will answer the central research question: can the use of force-feeding of prisoners and detainees on hunger strike be justified from a legal and medical-ethical perspective? If so: in what cases and under what circumstances? With this, I will initiate an assessment framework for States, prisons and other places of detention and their boards, and other people to adequately deal with the question of force-feeding of prisoners and detainees on hunger strike. This assessment framework is strongly influenced by the case law of the ECtHR and

EComHR as discussed in Chapter 5, as the European legal framework for deciding on force-feeding has been mainly developed in the case law of these two organs and, in this way, provides guidance to the Council of Europe Member States. Furthermore, the views on the legitimacy of force-feeding on the three national levels as discussed in Chapter 6 (the Netherlands, Germany, and England and Wales) will be used as an inspiration for the development of this assessment framework, and the basic principle and the proposed exception will be tested for these three jurisdictions. Although not included in the research question (after all, the research question only regards hunger strikers), in this chapter I will also briefly address the issue of force-feeding of incompetent prisoners and detainees who refuse food. As will be shown, different considerations apply to such groups of hunger strikers and incompetent prisoners and detainees. For this reason, I will elaborate on this distinction and the assessment of (in)competence first. Secondly, I will develop the basic principle that competent prisoners and detainees have the right to refuse food and that this right must be respected. Thirdly, I will go into the issue of food refusal by incompetent prisoners and detainees. Fourthly, I will formulate the exception to the basic rule, when the use of force-feeding of prisoners and detainees on hunger strike in my opinion can be justified from a legal and medical-ethical perspective. Here, I will also elaborate on the proposed exception in the light of Articles 3 and 8 ECHR, the role of the judge, the current possibilities for such judicial assessment that I propose in the Netherlands, Germany, and England and Wales, and the role of the physician's medical ethics in this exception.

2. THE ASSESSMENT OF (IN)COMPETENCE

As stated above, competent and incompetent prisoners and detainees form two distinct groups, to whom different considerations apply when considering the question of the possibilities of force-feeding in persons who refuse food.

As already highlighted in Ch. 2, § 6.2, an early assessment of competence is crucial in determining whether food refusal qualifies as a hunger strike or not (after all, only competent persons can be hunger strikers, see Ch. 1, § 2.5). Also, children and minors below a certain age are legally considered incompetent. In national legislation, age limits are stipulated to determine whether the minor or child himself, his parents, or both must consent before medical treatment can be performed. Still, other than these age limits suggest, in my opinion the principal question for children and minors must be whether a certain child or minor understands the information about his condition, appreciates the consequences of his choices and can weigh the relative risks and benefits of the options. The basic principle that adult persons are competent, unless demonstrated otherwise, is a relevant principle in hunger strikes, where the hunger striker's competence is often questioned, especially when the hunger striker perseveres in his actions to the detriment of his state of health.

The far-reaching consequences the hunger strike has, and its often rapidly evolving nature, requires continued assessment of competence. This assessment has far-reaching consequences for the determination of the legitimacy of forced medical interventions such as force-feeding, as will become clear in the next sections. For this reason, the determination of (in)competence must be provided with the necessary safeguards. Such safeguards include the assessment of the prisoner's or detainee's competence by a physician who is independent from the prison or other place of detention, and the possibility of a second opinion when requested by the hunger striker by a physician of his choice. Although physicians can be called for such an assessment, in difficult or sensitive cases a psychiatrist must be called upon because of his specific expertise.

3. BASIC PRINCIPLE: RESPECT FOR THE COMPETENT PRISONER'S AND DETAINEE'S RIGHT TO SELF-DETERMINATION

As a basic principle, prisoners and detainees have the right to go on hunger strike. No intervention is allowed if the prisoner or detainee makes an informed refusal to certain treatment, including the application of food or fluids.

The international human rights regime has acknowledged as a binding basic principle that prisoners and detainees enjoy the same human rights as other citizens whilst being deprived of their liberty, save the right to liberty.[1] The ECtHR (for example in the 2005 *Hirst* case) has explicitly ruled that prisoners – contrary to the idea of inherent limitations as illustrated by the EComHR – continue to enjoy all the fundamental rights and freedoms guaranteed under the ECHR save for the right to liberty. Accordingly, they are equally entitled to the protection against forced medical treatment that is offered on the basis of the rights as codified in the Articles 3 and 8 ECHR. The ECtHR has acknowledged that restrictions on non-absolute rights, such as personal autonomy under Article 8 ECHR, must be adequately justified. Such justification can be found in considerations of security, in particular the prevention of crime and disorder, which inevitable follows from the circumstances of imprisonment.[2] Force-feeding of a prisoner and detainees on hunger strike can, in my opinion, not be justified by such considerations of security. I acknowledge that some hunger strikes can, especially when undertaken in groups, severely disturb the security and internal order and discipline within the prison or other place of detention. This may lead to the transfer of individual hunger strikers to a different ward to appease the situation. Resorting to the measure of

1 See Ch. 3, § 4.

2 ECtHR 6 October 2005, *Hirst v the United Kingdom* (Grand Chamber), App. No. 74025/01, paragraph 69. See Ch. 3, § 4.

force-feeding one or more hunger strikers, in this respect, however would, in my opinion, be neither proportionate nor effective (as such forced intervention would probably intensify the dispute between the hunger strikers and the authorities). It can be concluded that in the case of a hunger strike, prisoners' and detainees' rights must be no more restricted than would be the case with people in the outside world. Accordingly, when a competent prisoner or detainee refuses food, this decision must be respected. No forced intervention against his will is possible, even if the decision to hunger strike leads to his death.

On the basis of this principle, respect for the competent prisoner's and detainee's informed refusal must be given. In Ch. 2, § 4.2, I elaborated on the elements of informed consent and informed refusal (i.e. competence, voluntariness, disclosure, recommendation and understanding). Although in several documents, such as the WMA Declaration of Malta, several of the elements of the concept are mentioned (for example noting that a refusal of food must be made voluntary), the concept of informed refusal as outlined in Ch. 2, § 4.2 provides a clear and comprehensive assessment framework to investigate whether a certain refusal is realised freely and is well-considered, and, accordingly, must be respected or not. In this assessment framework is reflected that in hunger strikes, the elements of voluntariness (that the patient is free from coercion or manipulation that might affect the outcome of the decision), disclosure (of the information that is necessary for the patient to make his decision), and understanding play a significant role. For an elaboration on these elements, and their relevance to hunger strikes, I refer to Ch. 2, § 4.2. Here, I will only add that although no force-feeding may be applied in the case of competent prisoners and detainees on hunger strike and the fact that consent of an incompetent person who refuses treatment can be overruled (as will be shown in the next section), providing information to the hunger striker throughout all phases of his strike remains crucial in the process of seeking consent. During the food refusal, the person who refuses food must consistently be fully informed about the consequences and other relevant aspects of his decision to stop eating. Decisions concerning the food refusal and hunger striking must be based on the full facts of the case, even when the prisoner's or detainee's consent is not required. Hunger strikers and food refusers must be given all relevant information concerning the decision they have made, without putting undue pressure on them. As with other patients, this information must be provided in a way that is comprehensible for the person involved. As stated above, when the hunger striker reaches an informed decision to refuse certain treatment, this refusal must be respected, similar to such decisions made by citizens in the community.

How does the State's responsibility to care for those it has deprived of their liberty relate to the prisoner's and detainee's right to refuse food? The State and its authorities have an obligation to secure human rights for those it has deprived of their liberty. Depriving persons of their liberty not only creates negative obligations for the State, for example to refrain from torture or other acts of ill-treatment, but

also positive obligations to take care of the person's health and life. As demonstrated in Chapter 5, case law of the EComHR and ECtHR shows that the main dilemma with force-feeding prisoners and detainees on hunger strike arises between the hunger striker's individual rights and the duty to care of the State and its authorities for those it has deprived of their liberty (Articles 3 and 8 versus Article 2 ECHR). The human rights balance has to be struck between these conflicting rights and obligations.

The ECtHR has emphasised the fact that prisoners find themselves in a vulnerable position and that the authorities are under a duty to protect them (see Ch. 3, § 5). In my opinion, the State's positive obligations under Article 2 of the ECHR to protect human life, however, cannot override the competent prisoner's or detainee's decision to refuse food. Positive obligations exist for the State to ensure that persons can exercise their human rights while in custody. Essentially, they are created to protect prisoners' rights and to compensate or repair human rights that are jeopardised by the loss of liberty. If the use of positive obligations *de facto* results in a limitation of prisoner's rights, such as is the case with force-feeding, this would go against the basic idea behind the creation of positive obligation on the part of the State. Besides this, positive obligations must be intended to benefit prisoners and detainees and the force-feeding of a hunger striker who consciously decides to refuse food is not in the best interests of the hunger striker, at least not how he perceives it. In conclusion, force-feeding justified by the State's positive obligations, turning the prisoner's and detainee's right to life into a far-reaching duty for the State, would go against the basic idea of the creation of positive obligations, which is to protect their rights. In my opinion, there is no place for positive obligations on the part of the State as grounds for intervening in the case of a competent prisoner or detainee who decides to refuse food. Such decision has to be respected, equal to respect for informed refusals of medical treatment by citizens in the outside world. That States, on the basis of Article 2 ECHR, are not obliged to intervene, and accordingly can rightfully abstain from intervention in a hunger strike by a competent prisoner or detainee has also been acknowledged by the ECtHR in the case of *Horoz*. In this case, the ECtHR stated that States are not responsible under Article 2 ECHR if they respect the hunger striker's wishes and the hunger striker subsequently dies as a result of his action.[3]

Although positive obligations on the basis of Article 2 ECHR do not urge intervention in the hunger strike against the wishes of the prisoner or detainee involved, in my opinion these positive obligations do in fact oblige States and State authorities to make efforts to end the hunger strike, by examining the hunger striker's motivations in an early stage and to investigate whether they can be mitigated by investigating possible solutions to the problem in order to resolve the hunger

[3] ECtHR 31 March 2009, *Horoz v Turkey,* App. No. 1639/03 (available in French only). See Ch. 5, § 3.4.8.

strike. Rieckenbrauck, medical director of the German correctional hospital of North Rhine-Westphalia, noted in this respect in 2009 that experience teaches that more than half of the hunger strikers had understandable reasons that could be mitigated or even be resolved.[4] As stated in Ch. 4, § 2.4, in most cases, a hunger strike is used as a communication method, to resume conversation with the other party involved in the conflict over which the hunger striker is protesting. Article 2 ECHR, in my opinion, obliges States to undertake efforts to prevent deaths from prolonged hunger strikes when it is in their power to resolve the hunger strike and a fatal outcome at an earlier stage. Obviously, no obligation exists to submit to the hunger striker's wishes in every case. Nevertheless, the State is obliged to seriously investigate the reasons behind the hunger strike, to assess the reasonableness of the arguments advanced and to assess whether this problem can be solved in order to prevent it from escalating. In this way, the State must look for ways to change the decision of the hunger striker, while respecting his wishes, other than resorting to force-feeding.

Although forced medical intervention on the basis of Article 2 ECHR is not required, positive obligations on the basis of this Article require that hunger strikers are provided with the necessary medical treatment.[5] This is in line with the idea behind the creation of positive obligations, i.e. that a person who is deprived of his liberty cannot provide for his own health care, and prisons and have a duty to actively compensate for this State-imposed inability of the prisoner or detainee to take care of himself (see Ch. 3, § 5). In my opinion, positive obligations not only oblige States to provide necessary medical treatment to hunger strikers, but also urge States to refrain from measures that worsen the situation of the hunger striker. Respect for the right to self-determination of the hunger striker must be reflected not only in the decision to refrain from force-feeding him, but also in how he is treated in more general terms, such as under which circumstances he is held. Custodial conditions, for example, must not be worsened as a result of a prisoner or detainee being on hunger strike.[6] The authorities must furthermore refrain from punitive measures, or measures who bear the character of blackmail or manipulation, such as purposely confronting the hunger striker with food or making facilities (such as a TV) dependent on the decision to stop hunger striking. Hunger strikers must never be placed in punishment cells because of their actions, nor be placed in observation or isolation cells, unless there is a medical reason to do

4 Rieckenbrauck 2009, p. 261

5 ECtHR 31 March 2009, *Horoz v Turkey,* App. No. 1639/03 (available in French only). See Ch. 5, § 3.4.8.

6 In a report on a visit to Armenia in 2002, the CPT also stated that vulnerable prisoners such as hunger strikers "should never be accommodated under material conditions which are inferior to those prevailing on normal locations", Armenia visit 2002, CPT/Inf (2004) 25, at 74, see Ch. 5, § 3.5.

so.[7] Medical assistance as well as custodial conditions may not be made dependent on the stopping or suspension of the hunger strike.[8] It can be concluded that also with respect to the supply of medical assistance and custodial conditions, no undue pressure must be put on the hunger striker to stop or suspend his hunger strike.

On the basis of the equivalence of care principle, prisons and other places of detention must provide a standard of health care that is equivalent to that available within the rest of the community. Still, it can be argued that hunger strikers constitute a special group that requires additional care. In the last two decades, the case law concerning Article 3 ECHR has shown a development in the way of requiring adequate care for special groups of prisoners that require additional medical care. As stated in Ch. 3, § 2.2.2, the ECtHR has acknowledged that Article 3 ECHR imposes positive obligations on the State to provide prisoners and detainees with the requisite medical assistance and adequate medical care, and the lack of medical care can amount to degrading treatment as prohibited under Article 3 ECHR. The requirement to provide prisoners and detainees with medical care extends beyond the mere treatment of their sickness, but also requires additional adequate care for those with special needs, such as dental care, which may include that the prisoner is provided with a set of dentures, special care and treatment of persons suffering from mental disorders, of disabled persons, of the elderly, and of drug addicts suffering from withdrawal symptoms (see Ch. 3, § 2.2.2, with references). Clearly, the greater the physical or medical needs of the individual, the more the State must do in terms of fulfilling their positive obligations under Article 3 ECHR. Prisoners and detainees on hunger strike, in my opinion, also form such a "vulnerable" and special group that requires additional medical care. In practice, this additional care can be realised by providing adequate counselling, treatment, information and consultation to the hunger striker. If the hunger striker persists in his actions this may also include providing palliative care. Besides medical care, providing spiritual or psychological counselling may be of equal importance.

It can be concluded that, as a basic principle, respect must be given to the decision by a competent prisoner or detainee who decides to refuse food. No intervention is allowed if the prisoner or detainee makes an informed refusal to certain treatment, including the application of food or fluids. A decision to refuse food or treatment by

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7 The Dutch Ombudsman ruled in a case concerning the placement of a detainee on hunger strike in an observation cell that such placement may be justified in order to monitor the intake of food and fluids by the hunger striker. Still, these cells must be furnished as normal cells (for example with a TV, and the objects that normally may be held in a cell). Report National Ombudsman, d.d. 14 December 2010, Report number: 2010/353. For a critical note on this report, see Jacobs & Den Otter 2011. In the CPT's 21st *General Report*, the CPT has dedicated a large part of the report to the issue of solitary confinement of prisoners; see CPT/Inf (2011) 28, paragraphs 53-64.

8 This is underlined in the WMA Declaration of Malta, under guideline 6, where it is stated that "[t]reatment or care of the hunger striker must not be conditional upon suspension of the hunger strike".

a competent hunger striker should be respected and no force-feeding may be applied, even when this can result in the hunger striker's death, apart from in exceptional circumstances, upon which I will elaborate in § 5 of this chapter. For the physician involved in the treatment of the prisoner or detainee on hunger strike, the same principle applies. Although he must treat his patient and must do everything to protect and ameliorate his health and life, his duty to care is limited by the person's informed refusal. If a competent hunger striker does not consent to treatment, the physician must respect his decision.

4. FOOD REFUSAL BY INCOMPETENT PRISONERS AND DETAINEES

As highlighted in Ch. 1, § 2.5, incompetent prisoners and detainees are not considered hunger strikers, but as food refusers. The answer to the question of the legitimacy of force-feeding (and artificial feeding, in the case of a comatose patient) of incompetent prisoners and detainees who refuse food is different than for those who are competent. A distinction can be made between prisoners and detainees who are incompetent at the moment they started to refuse food, and those who become incompetent as a result of a prolonged hunger strike. I will go into the situation of hunger strikers that become incompetent as a result of a prolonged food refusal first, as their legal position can be similar to that of competent hunger strikers as described in the previous section.

If a competent hunger striker perseveres in his action, a moment will inevitably occur when he becomes unconscious or lapses into a coma, or loses the ability to make a decision concerning further treatment (for example because he becomes severely mentally disturbed as a result of his action). Before this moment, when he is still competent to decide, it is very important that he has decided and expressed his will concerning medical intervention. In many cases, prisoners and detainees will have issued clear instructions, anticipating future incompetence as a result of a prolonged hunger strike, stating that they wish no intervention in such situation. An advance directive, when drawn up by a hunger striker when he is still competent, can be regarded as an extended form of his right to self-determination, covering for the time he will no longer be able to decide for himself. In this way, the hunger striker's competence is extended to the period envisaged in the advance directive. To these prisoners and detainees, the basic principle applies: their wishes must be respected by the authorities and the physician involved when the anticipated situation occurs, even if this may result in the hunger striker's death, just as with citizens in the outside world who have expressed their wishes on treatment in a written form. Express wishes concerning further (non-)treatment by the hunger striker can be expressed verbally, but are preferably laid down in writing. This is not only important for the hunger striker involved, but also for the medical staff involved in

his treatment, since such advance directive prevents evidentiary problems afterwards and indemnifies them against claims of not respecting the person's wishes. Because of the far-reaching consequences of such advance instructions, this matter must be dealt with carefully, and it must be explained to the hunger striker that he is free to review his decision at any time during the hunger strike.

When the hunger striker has not given such clear instructions for when he becomes incompetent as a result of a prolonged food refusal, the basic principle for incompetent food refusers applies, which I will explain below.

As stated in Ch. 2, § 6, people can be considered fully incompetent in only a couple of cases, in most cases people are declared incompetent for a limited range of decision-making tasks. Incompetent patients (i.e. fully incompetent patients or patients who lack capacity for a specific task) do not have the possibility or do not possess the capacity to perform a certain task and, accordingly, their decisions can – under circumstances – be overruled. The group of incompetent food refusers includes prisoners and detainees who are incompetent as a result of a mental disorder or mental impairment from the moment they started to refuse food and those persons who are incompetent as a result of a prolonged hunger strike and have signed no advance directive concerning treatment after their incompetence.

Where, with regard to competent prisoners and detainees, the positive obligations by the State on the basis of Article 2 ECHR are restricted by the hunger striker's own express wishes, with incompetent prisoners and detainees these positive obligations may be restricted by the informed refusal of a surrogate decision-maker who decides on the patient's behalf. As with citizens in the outside world, with incompetent persons in custody, others are in a position to decide in medical matters such as force-feeding. In such a situation, the person's wishes can be overruled, and decisions can be made in the person's best interests, which may include the application of force-feeding if his health becomes seriously threatened as a result of the refusal of food. The legal position of incompetent persons who find themselves in custody must be equivalent to that of patients in the outside world, including the possibility of appeal. As with patients in the free world, if family members have very different opinions or there is no family, or the physician has doubts as to whether the surrogate decision-maker is acting in the best interest of the person involved, a court must resolve the issue or appoint a surrogate decision-maker (see Ch. 2, § 7). National legislation may contain exceptions to the rule that surrogate decision-makers are not consulted, for example, in emergency situations. The principle that persons who are deprived of their liberty retain their human rights whilst in custody also, and maybe even especially, applies to incompetent patients because of their vulnerable position. On the basis of the State's positive obligations under Article 3 ECHR, prisoners and detainees must be provided with special care and treatment for their mental health problems. Besides, prisoners and detainees who are incompetent as a result of a mental disorder must be provided with treatment

for their condition in a place that is best equipped for such treatment, for example, a psychiatric hospital or the psychiatric ward of a prison.[9]

As with competent prisoners and detainees (as dealt with in the previous section), force-feeding must be applied in accordance with Article 3 ECHR, and may not amount to ill-treatment in the sense of this Article. In the case of *Herczegfalvy*, the ECtHR went into the issue of force-feeding of incompetent "hunger strikers".[10] In this case, the ECtHR stated that "[w]hile it is for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom they are therefore responsible, such patients nevertheless remain under the protection of Article 3 […], whose requirements permit of no derogation".[11] The accordance with Article 3 ECHR must be assessed with special vigilance, because of the "position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals". From this case it can furthermore be concluded that "[t]he established principles of medicine are admittedly decisive in such cases", and "a measure which is therapeutic necessary cannot be regarded as inhuman or degrading".[12] Compulsory medical treatment of mentally ill patients who cannot make rational decisions about their own treatment is permitted, but States have to be able to show that any particular course of treatment (such as force-feeding) was medically necessary in a particular case. Besides, the force used must be proportionate (in the case of *Herczegfalvy*, the ECtHR investigated whether the various measures complained of had been violent and excessively prolonged in assessing if Article 3 ECHR had been violated).[13] It can be concluded that with incompetent patients, medical necessity can – when convincingly shown to exist, and the treatment is applied with no more than appropriate force – justify the use of forced medical treatment, which may include force-feeding. In such case, the treatment neither constitutes ill-treatment on the basis of Article 3 ECHR, nor a violation of the patient's rights under Article 8 ECHR.

As seen above, the incompetent patient's decision to refuse food can – under certain circumstances – be overruled. The physician must treat his patient and must do everything to protect and ameliorate his health and life. Where, with regard to

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9 Cf. Article 35, paragraph 3, of the Council of Europe Recommendation Rec(2004)10 of the Committee of Ministers to member states concerning the protection of the human rights and dignity of persons with mental disorder that determines that "[i]nvoluntary treatment for mental disorder should not take place in penal institutions except in hospital units or medical units suitable for the treatment of mental disorder".

10 ECtHR 24 September 1992, *Herczegfalvy v Austria,* App. No. 10533/83, see Ch. 5, § 3.4.4.

11 Ibid., paragraph 82.

12 Ibid.

13 In this way, the criteria as used in *Herczegfalvy* in 1992 for incompetent patients predated the criteria as developed for competent hunger strikers in the 2005 case of *Nevmerzhitsky*.

competent prisoners and detainees, these positive obligations are restricted by the hunger striker's own express wishes, however, with incompetent prisoners and detainees the physician's duty can be restricted by the informed refusal of a surrogate decision-maker who decides on the patient's behalf.

5. EXCEPTION TO THE BASIC PRINCIPLE OF RESPECT FOR THE COMPETENT PRISONER'S RIGHT TO SELF-DETERMINATION

As stated in § 3 of this chapter, as a basic principle, prisoners and detainees have the right to go on hunger strike. No intervention is allowed when the prisoner or detainee makes an informed refusal to certain treatment, including the application of food or fluids.

One exception to the basic rule must be accepted. This exception is created for cases in which there are weighty interests in preserving the life of the hunger striker until a verdict in his trial has been reached. In such cases, the need to bring the prisoner to justice overrides the hunger striker's individual right to refuse food. Below, I will elaborate on this exception allowing legitimate intervention in a hunger strike through the use of force-feeding. In this, some of the arguments as illustrated in Chapter 4 in favour of force-feeding of hunger strikers can be detected. The main interest that can override the hunger striker's decision to refuse food is the need to make sure that the hunger striker lives to stand trial, as elaborated on in Ch. 4, § 3.6. Accordingly, the exception to the basic rule for competent prisoners only applies to prisoners in the pre-trial phase, not to sentenced prisoners or detainees. As noted in Ch. 4, § 3.6, if a hunger striker dies of starvation, he will not or no longer be able to stand trial, as trials end when the accused dies. But why can it be important to prevent such a self-inflicted death?

Weighty interests in preserving the life of the hunger striker can occur in cases where a trial is very important for (groups of) victims that seek redress for the suffering inflicted upon them (as noted in Ch. 4, § 3.6), such as in cases before international war crimes tribunals. Trials before such tribunals are often very important for (groups of) victims and their next of kin to obtain reparation for the crimes committed. If the hunger striker were to be allowed to die as a result of his action, the possibility for these victims to obtain redress in a court of law would be removed. Nevertheless, not only persons who are directly involved in a certain criminal case can have an interest in the trial to proceed as normal. More general social interests can also plead in favour of preserving the hunger striker's life before his trial takes place. Sometimes, criminal acts cause a big stir in society, and society would be severely disturbed by the death of the suspect before a trial takes place. Not only does a trial ensure that justice is done for victims and those who are directly involved in a case, but redress before a court can also serve as a

way of reparation for society, and a possibility to provide clarity on the facts of the case. This was demonstrated by the case of *Volkert van der G.* in the Netherlands.[14] Preventing the hunger striker from dying as a result of his hunger strike also facilitates the successful course of the proceedings, and the gathering of evidence: one of the most important aspects of the pre-trial detention. Pre-trial detention can then be used as a provisional coercive measure that is justified on the basis of the suspicion of the prisoner's involvement in a crime. During the pre-trial phase, the suspect is often the only person to clarify the motive and the specific facts of the case. In this way, the suspect is an important agent in the process of gathering of evidence and arriving at the truth. By not permitting the hunger strike to die while the case is before the court, he will remain available for interrogation and other activities that serve the interests of the investigation and the gathering of evidence. This is in line with the idea as described by Trechsel, that the pre-trial phase is characterised by a specific formal aim and that "the detention must be to bring the person before the competent legal authority".[15]

These above-mentioned interests to preserve the life of the hunger striker until a verdict in the trial has been reached can be closely intertwined, as was reflected in the Dutch case of *Volkert van der G.* and *Šešelj* before the ICTY (see Ch. 6, § 2.8 and Ch. 5, § 2.1.9). What also becomes apparent from these two cases is that force-feeding in such cases is often motivated by the authorities by emphasising their duty to care for the persons they have deprived of their liberty, while other interests seem to be the prime motives underlying the need to intervene. The case of Šešelj is, in my opinion, a clear example of referral to the duty to care for the health and life of the prisoner involved, where the real reason behind intervention was the prevention of the death of the hunger striker while the case was pending before the court. Although I acknowledge that the authorities' duty to care is in fact the most important legal argument in favour of intervention (and in the past sometimes even prevailed in deciding on cases of force-feeding and detainees on hunger strike, see for example, the 1984 case of *X v Germany* before the EComHR as discussed in Ch. 5, § 3.4.3), in § 3 of this chapter, I stated that, as a matter of principle, positive obligations on the basis of the State's duty to care for those it has deprived of their liberty cannot be used to overrule the prisoner's or detainee's right to refuse food. In cases where force-feeding is urged, in my opinion, the real motives behind intervention must be disclosed. In order to facilitate the assessment of the judge (as will be explained in § 5.2 of this chapter) it must be made clear what the precise interests involved that plead in favour of intervention by the requesting party are in order to be able to investigate the question of whether these interests can give rise to an exception to the basic rule of non-intervention in the case of competent hunger strikers.

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[14] See Ch. 6, § 2.8.

[15] Trechsel 2005, p. 423.

As stated in Ch. 4, § 3.6, societal and victims' interests as described above to preserve the life of the hunger striker not only play a role before a trial takes place, but also if a prisoner goes on hunger strike in prison *after* sentencing.

Still, in my opinion, legitimate intervention can only take place in the phase before the trial takes place: when the suspect finds himself in pre-trial detention. After all, the main interest to override the hunger striker's decision to refuse food is intervention to make sure that the hunger striker lives to stand trial, as stated above. During this trial, general interests of society will be taken into account and will also be taken into account in the punishment, and the same goes for interests of groups of victims. In the case of *Volkert van der G.*, for example, the courts had due regard to the impact the crime had on society, and the fact that the legal order was severely shocked by the offence.[16] In this way, their interests are already made allowance for in the judgment and the sentencing. As noted earlier, a trial means that justice can be done for victims and those who are directly involved in a case and can also serve as a way of providing reparation for society.

Sometimes, as noted in Ch. 4, § 3.6, force-feeding can be urged after the trial to prevent the prisoner from starving himself to "avoid" serving his sentence in full. Allowing a hunger striker to die would absolve him of personal accountability for his crime. This argument is especially controversial in the context of death row prisoners in the US.[17] In most jurisdictions, the retributive element in punishment requires no action from the prisoner, other than serving out the imposed sentence: the deprivation of liberty is itself the punishment. I am opposed to the idea that prisoners must be kept alive in order to serve their punishment. Above all, as included in the definition, a hunger strike is intended as a form of protest, and not intended as a means to die (which distinguishes it from suicide, see Ch. 1, § 3). I agree with Tagawa, where he, in reviewing whether the penological objective of retribution can justify the deprivation of the prisoner's right to hunger strike, states that attributing the hunger striker's potential death to the desire to escape punishment is illogical, since a prisoner's death by illness, accident or suicide is not generally regarded as an example of a prisoner "escaping" his punishment.[18] Besides, victims can be strongly

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16 The *Volkert van der G.* case was in first instance dealt with by the District Court of Amsterdam (*Rechtbank Amsterdam*), 15 April 2003, LJN: AF7291, who observed that the legal order was severely shocked by the offence, and in determining the sentence the feelings of the public at the time of the murder and the shock in society that was caused by the murder was taken into account ("*Het feit heeft in zijn algemeenheid de rechtsorde buitengewoon ernstig geschokt. […] Bij het bepalen van de hoogte van de straf heeft de strafrechter in casu bovendien rekening te houden met en kan hij niet voorbij gaan aan de gevoelens die bij een deel van de bevolking leefde ten tijde van de moord op het slachtoffer en aan de ongekend grote schok die de moord bij dat deel van de bevolking teweeg heeft gebracht.*") Similar considerations were taken by the Court of Appeal Amsterdam (*Hof Amsterdam*) 18 July 2003, LJN: AI0123 in the same case.

17 Silver 2005, p. 643.

18 Tagawa 1983, p. 591.

divided on the question of whether they desire that prisoners must be kept alive after their conviction in order to serve their punishment that was imposed by the judge. As already noted in Ch. 4, § 2.6, victims can feel relieved and maybe even gratified when the sentenced prisoner dies as a result of his hunger strike.

In conclusion, intervention through the use of force-feeding can only be justified before a trial takes place in order to make sure that the hunger striker lives to stand trial. The possibility to perform such intervention exists as long as no final decision in the case is reached. Nevertheless, since trials can cover a long period of time and societal and victims' interests as described above to preserve the life of the hunger striker may vary over time, repeated intervention may require a new judgment by the judge.

It must be emphasised that the measure of force-feeding on the basis of this exception is not meant as a punitive measure; the force-feeding is neither intended as a measure to punish the prisoner for his decision to go on hunger strike, nor intended to discourage him from continuing his protest.[19] As already stated in § 3 of this chapter, punitive aspects in the treatment of hunger strikers are not allowed, neither in deciding on force-feeding, nor in the treatment of the hunger striker or his custodial conditions.[20] Force-feeding in order to preserve the life of the hunger striker until a verdict in the trial has been reached in the exception outlined above must be solely directed to this purpose; the force-feeding may not be used to inflict additional suffering to the person involved. The force-feeding does not constitute a violation of the *nemo tenetur* principle, the defendant's right to remain silent and the privilege against self-incrimination, since force-feeding is not intended as a way to make the prisoner confess. If the hunger striker is determined to remain silent also after intervention this has to be respected. Although he must be informed of the possibility to apply force-feeding to him (as a part of informing the hunger striker on all the aspects and possible consequences of his decision), force-feeding may never be used to punish, intimidate or to put pressure on him to act in a certain way; it may solely be used as a means to keep the hunger striker alive until a verdict in his trial has been reached.

5.1. THE PROPOSED EXCEPTION IN THE LIGHT OF ARTICLES 3 AND 8 ECHR

How does an intervention through the use of force-feeding in the exceptional circumstance as expounded on above relate to Articles 3 and 8 ECHR, that, as

[19] The ECtHR dealt with the latter point in the case of *Ciorap* before the ECtHR, Ch. 5, § 3.4.7.

[20] This is in line with the viewpoint of the CPT, underlining that hunger strikes should be approached from a therapeutic rather than a punitive standpoint. Visit to Turkey, in 2000 (December) and 2001 (May), CPT/Inf (2001) 31, at 33. See Ch. 5, § 3.5.

described in Ch. 3, § 6.2.2.4, can protect the prisoner against forced medical intervention?

As demonstrated in Ch. 5, § 3.4, the ECtHR has left a wide degree of interpretation to Member States to decide on the issue of force-feeding of prisoners on hunger strike, and is in principle not opposed to force-feeding in competent hunger strikers. If States decide to apply force-feeding, such as in the exceptional circumstances as outlined above, this force-feeding nevertheless has to meet certain criteria. In considering whether force-feeding a hunger striker amounts to inhuman or degrading treatment or punishment or torture as prohibited by Article 3 ECHR, the ECtHR has ruled in the 2005 *Nevmerzhitsky* case that force-feeding, just like another measure which is of therapeutic necessity from the point of view of established principles of medicine, cannot in principle be regarded as inhuman and degrading. Nevertheless, three criteria have to be met: 1) the medical necessity must have been convincingly shown to exist, 2) the procedural guarantees for the decision to force-feed must be complied with, and 3) the manner in which the applicant is subjected to force-feeding during the hunger strike shall not transgress the threshold of a minimum level of severity as envisaged by Article 3 ECHR. Accordingly, when force-feeding is applied in the pre-trial phase, these criteria have to be met.

In the 2009 report on the Spanish hunger strike of prisoner De Juana (as discussed in Ch. 5, § 3.5), the CPT sought harmonisation with the *Nevmerzhitsky* criteria as provided by the ECtHR.[21] In the introductory part on "The management of De Juana's hunger strike" in Section B of the report, the CPT stated that

> "[i]f a decision is taken to force-feed a prisoner on hunger strike, in the CPT's view, such a decision should be based upon *medical necessity* and should be carried out under *suitable conditions* that reflect the medical nature of the measure. Further, the decision-making process should follow an established procedure, which contains sufficient safeguards, including *independent medical decision-making*. Also, *legal recourse* should be available and all aspects of the implementation of the decision should be adequately *monitored*.
>
> *The methods used to execute force-feeding* should not be unnecessarily painful and should be applied with skill and minimum force. More generally, force-feeding should infringe the physical integrity of the hunger striker as little as possible. Any resort to physical constraint should be strictly limited to that which is necessary to ensure the execution of the force-feeding. Such constraint should be handled as a medical matter."

Although the criteria of medical necessity and the use of a minimum amount of force had already been described by the ECtHR, the CPT here provided further substantiation to these criteria that, in my opinion, must also be observed.

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[21] Visit to Spain from 14 to 15 January 2007, CPT/Inf (2009) 10. See Ch. 5, § 3.5.

The exception as discussed in this section, fulfils the criteria as listed by the CPT and ECtHR. In my opinion, the decision-making process, which consists of judicial review of the proposed measure can be considered as "an established procedure, which contains sufficient safeguards". Furthermore, the judge can legitimise, but will not force the physician to cooperate in the application of force-feeding. In this way, the independent medical decision-making required by the CPT is safe-guarded. Overall independent medical decision-making can be ensured by appointing medical staff from outside the prison. The physician involved in the treatment of the hunger striker must determine when the medical necessity – as required by both the ECtHR and the CPT – to apply force-feeding in a certain case occurs. In the opinion of the ECtHR and CPT "medical necessity" is an important element in considering the legitimacy of force-feeding under Article 3 ECHR. To restrict the hunger striker's right to self-determination, medical necessity is required. As already emphasised in Ch. 5, § 3.4.6, the 2006 case of *Wilkinson* demonstrated that this medical necessity is not limited to life-saving treatment. Although this medical necessity must be interpreted narrowly in order not to undermine the idea of respect for his personal autonomy, with respect to hunger strikes this means that intervention can be justified before the hunger strike becomes life-threatening, for example when injuries of a permanent character occur (such as in the case of *X v Germany*, see Ch. 5, § 3.4.3). Intervention before the hunger strike becomes life-threatening can increase the hunger striker's changes of survival, because force-feeding after the hunger striker has lapsed into a coma is likely to be too late and will not result in the prisoner's survival (see Ch. 1, § 8.3). Determining medical necessity logically requires medical judgment. In the case of *Wilkinson*, the ECtHR noted, in this respect that "the decision as to what therapeutic methods are necessary is principally one for the national medical authorities: those authorities have a certain degree of interpretation in this respect since it is in the first place for them to evaluate the evidence in a particular case".[22] In the case of *Nevmerzhitsky*, the ECtHR required that this medical necessity is substantiated and documented, by requiring that the medical necessity "has been convincingly shown to exist". On the basis of the cases of *Wilkinson* and *Nevmerzhitsky*, it can be concluded that, in cases of prisoners and detainees on hunger strike, medical necessity is to be established by medical professionals, but must be substantiated and adequately documented.

According to the CPT, force-feeding has to be carried out under suitable conditions that reflect the medical nature of the measure, should be adequately monitored and the methods used should not be unnecessarily painful and should be applied with skill and minimum force. These requirements, as listed by the CPT, all require a careful and adequate procedure for the application of force-feeding. After the judge has authorised the physician to apply force-feeding, it is up to the physician to make sure that the procedure before, during and after the application of

[22] ECtHR 28 February 2006, *Wilkinson v UK,* App. No. 14659/02 (decision on admissibility).

force-feeding is provided in a careful and adequate way, and meets the professional standards for such procedure.

It can be concluded that force-feeding in a competent prisoner on hunger strike cannot be considered a violation of Article 3 ECHR, as long as above-mentioned criteria are met. But how does the exception to the basic rule that no force-feeding may be applied with competent hunger strikers as formulated in § 5 of this chapter relate to Article 8 ECHR?

The cases concerning the legitimacy of force-feeding in Chapter 5 show that the issue of force-feeding prisoners on hunger strike has mostly been discussed in cases concerning Article 3 ECHR. This, in my opinion, can be explained by the nature of the cases that have been brought before the ECtHR, which can all be characterised by the fierce way in which the force-feeding was applied and the amount of force that was used. When the ECtHR concluded that Article 3 ECHR was violated, it was unnecessary to examine the complaint under Article 8 ECHR separately. Article 8 ECHR, however, can also provide protection for prisoners against force-feeding covering the moral and physical integrity of the person.[23] Although the EComHR and ECtHR have never assessed the conformity of force-feeding of a competent hunger striker with Article 8 ECHR, the EComHR noted in the 1984 case of *X v Germany* that a hunger strike can lead to a conflict between an individual's *right to physical integrity* and the State's positive obligations under Article 2 ECHR.[24] Force-feeding is a violation of a person's right to physical integrity. But can this violation be justified? In contrast to Article 3 ECHR, Article 8 ECHR is not absolute, and the right to physical integrity can be limited on the basis of the second paragraph. In the case of *Pretty*, the ECtHR noted "[t]he more serious the harm involved the more heavily will weigh in the balance considerations of public health and safety against the countervailing principle of personal autonomy".[25] Still, such measures need justification in terms of the second paragraph. In my opinion, interference on the physical integrity of the hunger striking prisoner in the exception to the basic rule that no force-feeding may be applied with competent hunger strikers as formulated in § 5 of this chapter can be justified on the basis of the limitation as laid down in the second paragraph of Article 8 ECHR. This limitation clause demands that 1) any interference with the ECHR's rights is "in accordance with the law" or "prescribed by law"; 2) this interference must pursue any of the legitimate aims that are exhaustively laid down in the second paragraph; and 3) this interference must be considered "necessary in a democratic society". These standards were described and explored in Ch. 3, § 6.2.2.6.

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23 See Ch. 3, § 6.2.2.

24 EComHR 9 May 1984, *X v Germany*, App. No. 10565/83, 7 E.H.R.R. 135, p. 153 and ECtHR 5 April 2005, *Nevmerzhitsky v Ukraine,* App. No. 54825/00, paragraph 93.

25 ECtHR 29 April 2002, *Pretty v the United Kingdom,* App. No. 2346/02, paragraph 74.

On the basis of the first requirement, the possibility to force-feed prisoners on hunger strike as explained in § 5 of this chapter must have some basis in domestic law, and must be accessible to the citizens, so that they can foresee the exact scope and meaning of the provision so that they can adapt their conduct. The second standard requires that the interference must pursue any of the legitimate aims laid down in paragraph 2 of the Article, i.e. national security, public safety or the economic well-being of the country, the prevention of disorder or crime, the protection of health or morals, or the protection of the rights and freedoms of others. In my opinion, force-feeding in the case of the exception as formulated in § 5 of this chapter pursues the interests of the prevention of disorder or crime. In this exception, force-feeding is meant to prevent the hunger striker dying as a result of his hunger strike before the trial. Keeping the hunger striker alive until a verdict in the trial has been reached facilitates the course of justice, which can be of particular importance for groups of victims who are directly affected by the offence, but also for society to serve as a way of reparation, and a possibility to provide clarity on the facts of the case. In this way, preventing the hunger striker dying before this moment is aimed at preventing public turmoil, and serves the interests of the prevention of disorder or crime.

That the danger of great social unrest follows the interests of the prevention of disorder or crime was acknowledged by the ECtHR in the case of the permanent camera monitoring of Volkert van der G.[26] Although the ECtHR accepted that such permanent camera monitoring constituted an interference with his right to respect for his private life under Article 8, first paragraph, ECHR, the ECtHR noted that

> "the measure was imposed in order to prevent the applicant's escape or any harm to his health, which would aggravate the great social unrest that had already been caused by the politician's murder [Pim Fortuyn, who was murdered by Volkert van der G.], the Court finds that the impugned measure pursued the legitimate aims of public safety and the prevention of disorder and crime."

As noted in Ch. 3, § 6.2.2.6, the ECtHR has very rarely found a violation of ECHR by reference to this standard. The most significant interpretation issues arise in dealing with the third standard, that requires that the interference is "necessary in a democratic society". The ECtHR has consistently held that the adjective "necessary" in the second paragraph of Article 8 ECHR implies that the interference must correspond to a "pressing social need". In addition, the intervention must be "proportionate to the legitimate aim pursued".[27] In my opinion, force-feeding in the case of the exception as formulated in § 5 of this chapter is justified by a

[26] ECtHR 1 June 2004, *Volkert van der Graaf v the Netherlands,* App. No. 8704/03 (decision on admissibility).

[27] See Ch. 3, § 6.2.2.6.

pressing social need, which is formed by the need of society and groups of victims to see that the prisoner lives to stand trial. Also, the interference with the rights protected in Article 8, first paragraph, is no greater than is necessary to address that pressing social need. As stated in § 3 of this chapter, positive obligations not only urge States to provide the hunger striker with necessary medical treatment on the basis of Article 2 ECHR, but also oblige State and State authorities to examine the hunger striker's motivations at an early stage, and to investigate whether they can be mitigated by investigating possible solutions to the problem in order to resolve the hunger strike. In this way, States are obliged to prevent deaths from prolonged hunger strikes when it is in their power to resolve the hunger strike and a fatal outcome at an earlier stage. This is in line with the reasoning adopted by the ECtHR in the cases of *Keenan* and *Renolde*, that show that the authorities must take steps that can reasonably be expected from the State and its authorities to prevent the death of the prisoner or detainee involved, having regard to the information available at the time, and that (*Keenan*) first of all general measures and precautions must be employed to diminish the opportunities for self-harm, without infringing on personal autonomy.[28] When such attempts fail, force-feeding may be used as a last resort when justified by a pressing social need to prevent the hunger striker from dying before his trial. As a result, force-feeding under these circumstances can be considered a proportionate response to the legitimate aim sought to be achieved: it not only serves as a response to a pressing social need, but also stands the test of proportionality in such cases. Force-feeding in the case of the exception as formulated in § 5 of this chapter, in this way, can accordingly be qualified as "necessary in a democratic society".

It can be concluded that interference in the prisoner's physical integrity through the use of force-feeding in the case of the exception as formulated in § 5 of this chapter can be justified on the basis of Article 8, second paragraph, ECHR. That general interests of society can overrule the prisoner's wishes has already been acknowledged by the ECtHR in the above-mentioned case of *Volkert van der G.*[29] In this case, the ECtHR stated that

> "The Court considers that placing a person under permanent camera surveillance whilst in detention – which already entails a considerable limitation on a person's privacy – has to be regarded as a serious interference with the individual's right to respect for his or her privacy. On the other hand, the killing of Mr Fortuyn – perceived by many as a direct attack on democracy – caused widespread reactions of shock and indignation in Netherlands society. The Court acknowledges that the applicant's detention placed an exceptionally heavy responsibility on the penitentiary

[28] See Ch. 3, § 5.

[29] ECtHR 1 June 2004, *Volkert van der Graaf v the Netherlands,* App. No. 8704/03 (decision on admissibility).

> authorities to prevent the applicant from escaping or from being harmed, either by himself or otherwise. This responsibility stemmed directly from the fact that the Netherlands authorities rightly considered it to be of the utmost importance that, in order to appease and prevent the great public unrest caused by the killing of Mr Fortuyn, the applicant be brought to trial."

Although the ECtHR here acknowledged that camera monitoring raises an issue under the right to privacy under Article 8 ECHR, this interference was justified by the responsibility of the authorities to secure the prisoner's deprivation of liberty or to prevent him being harmed. Here, the ECtHR did not refer to the duty of the authorities to care for the prisoner's health, but acknowledged that the camera monitoring was solely intended as a way of making sure that the prisoner would not be harmed by his own actions, because of the importance of him standing trial. With this, the ECtHR recognised the importance felt by the Dutch authorities to make sure that the prisoner would be able to stand trial, as this trial was important in order to appease and prevent great public unrest in Dutch society.

It must be noted that this case dealt with camera monitoring and cannot automatically be applied to force-feeding, which is a direct and rather intrusive intervention in the prisoner's body which can – under circumstances – even amount to torture in the sense of Article 3 ECHR (see, for example, the *Nevmerzhitsky* case). Nevertheless, the 2004 case of *Volkert van der G.* provides further substantiation to the argument that also force-feeding in a hunger strike may be urged by weighty interests in preserving the life of the hunger striker until a verdict in the trial has been reached as formulated in § 5 of this chapter.

5.2. THE ROLE OF THE JUDGE IN THE PROPOSED EXCEPTION

On a national level, decision-making on force-feeding can be delegated to several parties. As described in Chapter 6, in the Netherlands and Germany the prison authorities who decide on the application of force-feeding, while in England and Wales the physician decides. In my opinion, it should neither be the prison authorities nor the physician who decide on this matter, but it must be left to the judge to balance all the relevant rights and interests at stake. The judge's task is to weigh the interests in preventing starvation against the competent prisoner's express wish to refuse food.

Why should this decision-making authority be delegated to a judge instead of to, for example, the prison authorities? In my opinion, the prison authorities are not best suited to decide on this matter, as this matter falls outside their competence and professionalism. Prison authorities are first and foremost charged with the management of a prison. The evaluation of the evident weighty interests in preserving the life of the hunger striker, and the relation of these interests to the individual rights of the

prisoner, transcends the interest of the prison at large and, as a result, goes beyond the competence and professionalism of the prison authorities. Besides, the prison authorities can be involved as a party in the conflict to which the hunger striker is protesting with his actions, for example if a hunger striker is protesting against the conditions under which he is held. By leaving the assessment on force-feeding to a judge, this assessment is also separated from the political issues of the day. As opposed to the prison authorities who can be subject to influences by the government to decide in a certain way, a judge is independent and impartial.

The physician in England and Wales is in charge of making medical treatment decisions, including the decision whether or not to apply force-feeding. While in England and Wales the medical approach to hunger strikes is chosen, in a human rights approach interests that oppose an absolute right to respect for the hunger striker's wish to refuse food are also taken into account (see under § 3 of the introduction to this book). The assessment of whether the proposed exception to the basic rule that no intervention in competent prisoners on hunger strike can be applied involves a legal evaluation of the evident interests in preserving the life of the hunger striker until a verdict in the trial has been reached, an assessment which falls also outside the medical competence and professionalism of the physician. Besides, by delegating decision-making authority to a judge instead of to a physician, the physician does not become a party to a conflict to which he is not involved, since a hunger strike by a prisoner is in most cases essentially a conflict between the hunger striker and the State and its authorities.

Because of the possible rapid evolving nature of the hunger strike, it is important that shortly after the beginning of the hunger strike, the intention of the hunger striker is examined in order to determine whether he is serious in his actions, and determined to continue it. In the case of a hunger striker (i.e. a determined effort by a mentally competent person who has indicated that he refuses food as a form of protest) where there are evident weighty interests in preserving the life of the hunger striker until the verdict in a trial has been reached, or such interests are likely to occur during the process of the hunger strike, the prison governor has to report the hunger strike forthwith to the relevant authority to decide whether legal proceedings will be instituted to request force-feeding.[30] A rapid decision by the judge on the force-feeding is not only important for the hunger striker involved, but also for other parties involved in the hunger strike, who are then provided with clarity on the expected response.

[30] For the Netherlands, the authority to decide whether legal proceedings will be instituted to request force-feeding before the court is the Minister of Justice, for England and Wales this is the Department of Health. For Germany, the relevant authority is the investigating judge, who has independent authority to decide on the force-feeding of a competent prisoner on hunger strike in the pre-trial phase. I will elaborate on this in the next section.

In investigating the legitimacy of force-feeding, the judge will make a substantial review of all the interests involved. The judge will investigate whether the measure of force-feeding in a specific case is proportionate and is requested as a final alternative. In evaluating the prisoner's interests in being protected against force-feeding an advance directive has to be taken into account. As stated in § 3 of this chapter, positive obligations compel States to investigate whether the hunger striker's demands can be mitigated in an early stage; the State must explore the possibilities of resolving the hunger strike, other than resorting to force-feeding. In order to be able to fully investigate this, as well as the multitude of weighty interests involved, the judge must perform a substantive review of the grounds advanced to intervene in a certain hunger strike. A mere test of reasonableness, in my opinion, does not suffice here. As such cases will not exist frequently (in the majority of cases of hunger strike no weighty interests bearing on the hunger striker will exist and the basic principle that no force-feeding is possible in the case of a competent prisoner on hunger strike will be applied), it can be considered to place cases concerning force-feeding of hunger striker with one court because of the concentration of expertise.

5.3. THE PROPOSED EXCEPTION AND THE SITUATION IN THE NETHERLANDS, GERMANY, AND ENGLAND AND WALES

The current possibilities to obtain legal remedy before force-feeding takes place in the Netherlands, Germany, and England and Wales have been described in Chapter 6. Below, I will investigate how these possibilities relate to the exception as proposed in the previous sections.

5.3.1. The Netherlands

In the Netherlands, as described in Ch. 6, § 2.3, on the basis of current legislation, the governor may oblige a prisoner to acquiesce to having a specific medical intervention carried out on him if in the opinion of a physician this intervention is necessary to avert serious risk to the health or safety of the prisoner or of others (cf. Article 32 PPA). Although Minister of Justice Donner stated during the hunger strike of Volkert van der G. in 2002 that Article 32 PPA could be used to apply force-feeding to him (see Ch. 6, § 2.8), in my opinion there are fundamental objections to the application of Article 32 PPA on the question of force-feeding of competent prisoners and detainees on hunger strikes.

In my opinion, the current Article 32 PPA has no independent significant meaning in the case of a competent prisoner on hunger strike. As already mentioned in Ch. 6, § 2.5, in the legislative history of this Article it is noted that this stipulation was specifically created for the increasing number of prisoners with severe mental disorders, who manifest uncontrolled, and without medical intervention

uncontrollable, behaviour. Practice also shows that Article 32 PPA is almost solely used in mentally disordered persons, mostly psychotic prisoners (see Ch. 6, § 2.3). It is a patently obvious that it is a different situation to that of a competent hunger striker who freely and consciously decides to refuse food as a form of protest. The different approach to hunger strikes was also acknowledged by the legislator (as reflected in the legislative history of Article 32 PPA), stating that in hunger strikes a different approach must be employed, taking the prisoner's own free will as the basic assumption. Here, the legislator also referred to the WMA Declaration of Tokyo that underlines the basic principle that, if a prisoner refuses food and is assessed as capable of forming an unimpaired judgment of the possible consequences (i.e. is competent), he may not be force-fed. The legislator also indicated that only when the prisoner is assessed to be incompetent, force-feeding or artificial feeding could fall within the definition of a medical intervention in the sense of Article 32 PPA, as long as this intervention is necessary to avert serious risk to the health or safety of the prisoner or of others (see Ch. 6, § 2.5). I agree with the legislator's approach that distinguishes between the group of mentally disordered persons to whom Article 32 PPA applies, and the specific situation of competent prisoners on hunger strike. In my opinion, Article 32 PPA can only be applied in the case of incompetent food refusers, if in the opinion of a physician force-feeding is necessary to avert serious risk to the health or safety of the prisoner or of others, and it has no independent significant meaning in the case of a competent prisoner on hunger strike.

If, however, Article 32 PPA were to be interpreted so broadly that it could cover the situation of a competent prisoner on hunger strike, in line with Minister of Justice Donner's opinion as expressed in 2002, the application of this Article would in my opinion still be problematic. As elaborated on in § 3 of this chapter, as a basic principle, prisoners and detainees have the right to go on hunger strike, and no intervention is allowed if the prisoner or detainee makes an informed refusal to certain treatment, including the application of food or fluids. The only exception to the basic principle as described in § 5 of this chapter is created for cases where there are weighty interests in preserving the life of the hunger striker until a verdict in the trial has been reached. The question of whether the need to bring the prisoner to justice overrides the hunger striker's individual right to refuse food in a particular case must be addressed by an impartial and independent judge. This decision must not be left to the prison governor as determined by Article 32 PPA, as this matter falls outside his competence and professionalism.[31] I acknowledge that, on the basis of current legislation, a prisoner confronted with force-feeding on the basis of Article 32 PPA has possibilities for legal remedy before and after the moment the prisoner governor has decided to oblige a prisoner to acquiesce to having a specific medical intervention carried out on him on the basis of Article 32 PPA, which I explored in Ch. 6, § 2.10. Because of the fact that a decision by the

[31] As stated in the previous section.

governor is needed in order to lodge the proceedings provided by the PPA and the Penitentiary Order, and the problematic time span of the complaints procedure, these procedures do not suffice to what is envisaged with the judicial assessment as proposed in my exception. Also, the Complaints Committee is not in a position to examine the variety of all the weighty interests involved, all the more so considering the fact that the Complaints Committee will not perform a substantive review of the grounds advanced, but will only perform a mere test of reasonableness, according to Article 68 PPA.[32] The possibility for interim injunction proceedings as provided by the civil law does not suffice in the light of what has been proposed in § 5 of this chapter either, as this merely serves as a safety net when no other possibility for legal remedy is available. Moreover, this way of judicial assessment does not concur with the basic rule that no intervention in a competent prisoner's hunger strike is allowed, and force-feeding in the proposed exception may only be performed *after* judicial authorisation has been obtained. In my opinion, intervention in a hunger strike through the use of force-feeding is such a far-reaching and invasive measure that it must not be made dependant on the response and resistance of the hunger striker (who might already be significantly weakened by his actions) to this decision.

In my opinion, a separate stipulation for the situation of prisoners on hunger strike must be created to clarify the relation between Article 32 PPA and force-feeding of hunger strikers and to ameliorate the legal position of prisoners on hunger strike. This can be done following the existing rules, for example, by adding a new paragraph to the current Article 32, or the creation of an Article 32a PPA for this purpose, formulating that Article 32 PPA has no independent significant meaning in the case of competent prisoners on hunger strike, and the basic rule that no intervention is allowed when the prisoner or detainee makes an informed refusal to certain treatment, including the application of food or fluids. In my opinion, a procedure to request permission to apply force-feeding in a specific case of hunger strike before the court can be instituted by the Minister of Security and Justice, as a keeper of the general interests of society and the responsible authority for those who are being deprived of their liberty, after being notified about the hunger strike by the prison governor (see § 1 of this chapter). In the proposed stipulation, only the exception to this basic rule as proposed in § 5 of this chapter must be formulated. On the basis of this exception, the competent Minister of Justice may instruct the prison governor to oblige a prisoner to acquiesce to having force-feeding carried out on him when he has obtained judicial permission for this intervention. An option to centralise cases concerning force-feeding of prisoners on hunger strike can be

[32] Article 68, paragraph 2, of the PPA states that "If the Complaints Committee is of the opinion that the decision to which the complaint relates: a) is contrary to a statutory regulation in force in the institution or a stipulation binding upon all parties of a treaty in force in the Netherlands; or b) must in weighing up all relevant interests be deemed *unreasonable or unfair*, it shall declare the complaint founded and annul all or part of the decision [emphasis added]."

to attribute these cases to the Parole Appeals Section (*penitentiaire kamer*) of the Arnhem Court of Appeal. This court is the only court of appeal with regard to cases in the field of penal law, *inter alia*, dealing with appeal cases concerning the extension of a hospital order. Once judicial permission is obtained, the prison governor may instruct the prison governor to request the prison physician to apply force-feeding to the hunger striker. Here, the prison governor has no decision-making power, he acts solely as an intermediary towards the final application of the force-feeding.

Once the judge has declared force-feeding admissible, he provides legitimisation to the treating physician to act against the prisoner's wishes (but he does not oblige the physician to apply force-feeding). In my view, the decision by the judge protects the physician against liability, criminal and disciplinary prosecution if the physician decides to apply force-feeding.[33]

5.3.2. Germany

As demonstrated in Ch. 6, § 3.8, with pre-trial prisoners in Germany, it is not the prison authorities who decide on the application of force-feeding, but an investigating judge (*Haftrichter*) who decides with regard to necessary measures or restrictions during detention (see Section 119, paragraph 6, of the Code of Criminal Procedure, *Strafprozeßordnung*). The historic development of Section 101 of the Enforcement of Punishments Act (see Ch. 6, § 3.4 and 3.5) shows that the assessment of force-feeding a hunger striker has always been strongly influenced by third parties' interests, principally the interest of protection of State authority and law enforcement against discredit and blackmail. Current legislation still permits intervention through the use of force-feeding a competent prisoner on hunger strike (see Ch. 6, § 3.5 et seq.). In the case of weighty interests that plead in favour of preserving the life of the hunger striker before his trial, these interests can be advanced by the public prosecutor in the procedure, as he and the prisoner are heard beforehand (see Ch. 6, § 3.8). The investigating judge will weigh all the interests involved, both in favour and against force-feeding. The decision of the investigating judge must state the grounds on which it is based. The execution of the coercive measure is time-limited. Its termination must be communicated to the investigating judge, who will decide on the continuation of the coercive measure.[34] In Germany, just like in the Netherlands, the question of force-feeding will, in most cases, arise when the situation becomes critical. Section 101 of the Enforcement of Punishments Act determines that force-feeding is only possible "in case of serious danger to the prisoner's health, or in case of danger to other persons' health". Nevertheless, on the basis of Article 119 of the Code of Criminal Procedure, sixth

[33] I will elaborate on the physician's medical ethics in relation to the proposed exception in § 5.4 of this chapter.

[34] Julius et al. 2009, p. 733.

paragraph, the Public Prosecutor and the prison governor can arrange provisional orders. Afterwards, they require the approval of the judge. When the prisoner has a legal interest in the review of this provisional order – which in my opinion with force-feeding most often will be the case – he can request an examination of the order by the investigating judge.[35]

It can be concluded that in Germany the possibility for judicial review of the decision to force-feed is already available under national law. In this assessment by the examining judge, an examination of all the interests involved is possible that allows not only for the prisoner's interests to be taken into account, but also weighty interests that argue in favour of preserving the life of the prisoner before his trial. In the case of a rapidly evolving hunger strike, provisional orders are possible in order to keep the prisoner alive if his situation should become critical before permission of the judge is obtained. In this way, the criteria for the exception to the basic rule that no intervention is allowed in competent prisoners on hunger strike as described in Ch. 7, § 5 are met. Nevertheless, a specification of the grounds of the exception to the basic rule that no intervention is allowed with competent prisoners on hunger strike as specified in § 5 of this chapter would be recommended.

5.3.3. England and Wales

As described in Ch. 6, § 4, the current policy in England and Wales is to regard force-feeding as a medical matter, to be decided on by the physician. Still, the court may be asked to assess physician's decisions, also concerning force-feeding, as the cases enumerated in Ch. 6, § 4.6 and 4.8 show. Judicial review is a form of court proceedings in which a judge reviews the lawfulness of a decision or action by a public body (see Ch. 6, § 4.3). When weighty interests in preserving the life of the hunger striker occur and the authorities concerned would consider force-feeding desirable, they can seek declaratory relief to lawfully intervene in the hunger strike and to apply force-feeding to the competent prisoner on hunger strike. In such case, the judge has to decide if the third parties' interests involved form such exceptional and stringent circumstances that it can set aside the principle of respect for the prisoner's right to self-determination in medical cases. If the question of force-feeding arises, the courts can give rulings at all hours and very quickly. In this way, the court can consider the facts of the case and issue a declaration about the lawfulness of the proposed intervention. Such a case would probably be instigated by the Department of Health, which is currently charged with the health of the offender. In the case of *R v Home Secretary, ex parte Robb*, Thorpe J. investigated the developments in other common law jurisdictions, particularly the US, with regard to hunger strikes. He concluded that no third parties' interests were advanced that required adjudication in that case, and that for that reason it would be unwise for

[35] Julius et al. 2009, p. 734.

him to make a finding in this issue (see Ch. 6, § 4.6). Still, by leaving the option open that such third parties' interests can occur, he seems to be of the opinion that such interests can play a role in deciding on force-feeding, and have to be weighed when deciding on the proposed intervention. In the case of *R v Collins, ex parte Brady*, Maurice Kay J. noted – similar to the case of *R v Home Secretary, ex parte Robb* – that no third parties' interests were advanced. Still, in an *obiter dictum* he goes as far as expressing view on the matter, stating that

It would be a disappointment to me if I were constrained by authority from finding in favour of the respondents on this issue. My impression is that I would not be. Moreover, it would seem to me to be a matter for deep regret if the law has developed to a point in this area where the rights of a patient count for everything and other ethical values and institutional integrity count for nothing.

Accordingly, Maurice Kay J. seemed to be of the opinion that third parties' interests may overrule a self-determined hunger striker and that these interests may enable intervention. Although I acknowledge that in English law, the current policy strongly adheres to the idea of respect for the prisoner's self-determination in almost absolute form, in a case where weighty interests occur that argue in favour of intervention before a trial takes place, this case could be brought to the court. In England and Wales, the legitimacy of force-feeding of a prisoner on hunger strike remains to be decided upon on a case-by-case basis, and the above-mentioned opinions of the judges involved in these two cases show that third parties' interests can in fact play a role and – in my opinion – could even carry significant weight in deciding on force-feeding.

5.4. THE PROPOSED EXCEPTION AND THE PHYSICIAN'S MEDICAL ETHICS

As indicated in the previous chapters, the role of the physician in the treatment of hunger strikers is crucial. In most cases, physicians are closely involved in hunger strikes, not only in the last phase of the hunger strike when the question of force-feeding arises, but during the entire period of the hunger strike, monitoring the hunger striker's condition and providing assistance and consultation to him. Often, the physician builds up a relationship of trust with the hunger striker and sometimes he will even act as a mediator in the conflict. In this respect, it is highly recommended that a physician who is independent from the prison is approached for the treatment of the hunger striker. In my opinion, the documents such as the manual of the Dutch Johannes Wier Foundation, the guidelines by the Department of Health in England, and the WMA Declaration of Malta provide valuable guidelines for physicians and other health personnel for the treatment of hunger strikers. All these documents elaborate on the question how to approach the delicate issue of hunger strikes in a careful and humane way.

The possibility to intervene through the use of force-feeding in the exception as proposed in § 5 of this chapter seems to oppose to the core message of these documents: that force-feeding is not allowed in the case of competent prisoners on hunger strike. Regarding force-feeding, the WMA in its Declarations is abundantly clear on the issue. The 1975 Declaration of Tokyo in Article 5 (after the 2006 revision Article 6) stated that "[w]here a prisoner refuses nourishment and is considered by the physician as capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially". The two subsequent versions of the Declaration of Malta (1991, with revisions in 1992 and 2006) reiterated that "[f]orcible feeding is never ethically acceptable. Even if intended to benefit, feeding accompanied by threats, coercion, force or use of physical restraints is a form of inhuman and degrading treatment".[36] How does this relate to the possibility to force-feed competent prisoner as I propose?

First of all, can the physician be forced to apply force-feeding when declared permissible by the judge? No, he cannot. If the judge declares force-feeding admissible, he only provides legitimisation to the treating physician to act against the prisoner's wishes. In other words, he does not *oblige* the physician to apply force-feeding. In this way, the physician remains free to choose whether, and if so, when and how, he will apply force-feeding to the hunger striker. In my view, the decision by the judge protects the physician against liability, criminal and disciplinary prosecution if the physician decides to apply force-feeding. Force-feeding may only be applied by trained medical staff. If the treating physician can demonstrate that he has performed the force-feeding *lege artis*, and he has given careful consideration to his decision to intervene (*inter alia* not only taking into account the benefits of force-feeding, but also considering the medical risks of the force-feeding), he must remain free from such criminal and disciplinary prosecution.

But will a physician be prepared to apply force-feeding to a hunger striker when the judge has declared that the application of force-feeding in a specific case is justified? The WMA Declarations are merely guidelines, and they have no binding effect (see Ch. 5, § 2.2). Still, as mentioned earlier, for physicians they are valuable documents for the treatment of hunger strikers. I see points of departure for physicians to argue that they are allowed to intervene in a hunger strike through the use of force-feeding if the judge finds that there weighty interests in preserving the life of the hunger striker until a verdict in the trial has been reached, which set aside the prisoner's wish to refuse food.

In my opinion, the Declaration of Tokyo must be seen against the background of the Declaration, i.e. a background of torture. As highlighted in Ch. 5, § 2.2.1, force-feeding is prohibited in this Declaration because it could serve as a way to revive the prisoner in order to torture him further. Article 5 applies to force-feeding such as conducted in Guantánamo Bay (as described by the UN Special Rapporteurs, see

[36] See Ch. 5, § 2.2.1 and 2.2.2.

Ch. 5, § 2.1.8), but is a completely different situation to that under the exception as proposed above, since this Article in the Declaration of Tokyo is not about hunger strikers who refuse food as a form of protest, as envisaged in the proposed exception. Moreover, the application of the force-feeding in the proposed exception is explicitly not intended as a punitive measure, nor intended as a measure to revive the prisoner in order to expose him to torture or other ill-treatment. For this reason, Article 5 of the Declaration of Tokyo in my opinion does not oppose the proposed exception.

Also, the WMA Declaration of Malta does not stand in the way of force-feeding a competent hunger striker by a physician when allowed by the judge, since the main idea as upheld in this Declaration, i.e. that the hunger striker's autonomy must be respected at all times (as codified in Principle 2), no longer applies in full when this has been overruled by the judge. If force-feeding is declared admissible by a judge in a certain case, he acknowledges that – after weighing all the interests involved in the case – there are factors that override the hunger striker's right to self-determination. In this way, he sets aside the principle of absolute respect for the hunger striker's wishes in a specific case, and determines that a necessary differentiation is made to this Principle. Accordingly, the primacy of respect for the hunger striker's autonomy as illustrated in the Declaration of Malta no longer applies in full, and the judge authorises the physician to act against the hunger striker's wishes. In this way, the question of whether the physician may legitimately go against the prisoner's wishes and override his autonomy has already been answered by the judge, and no longer has to be answered by the treating physician, as envisaged by the WMA Declaration of Malta.

Moreover, the exception as formulated in § 5 of this chapter, is in accordance with one of the other spearheads of the WMA as reflected in the Declaration of Malta, i.e. that a physician must always decide autonomously, without being pressured to decide in a certain fashion by third parties. Article 5 of the Declaration of Malta looks at the issue of dual loyalties, stating that the physician's "primary obligation is to the individual patient". Under Article 6, which deals with the issue of clinical independence, the Declaration states that "[p]hysicians must remain objective in their assessments and not allow third parties to influence their medical judgement". In other words: a physician must remain objective and must always decide independently of third parties involved in the matter. This idea is also underlined in the CPT Standards[37] and the Council of Europe's Recommendation Concerning the Ethical and Organisational Aspects of Health Care in Prison, the latter stating that "health care personnel should operate with complete independence within the bounds of their qualifications and competence".[38] In the proposed exception – unlike in many

[37] The CPT Standards. "Substantive" sections of the CPT's General Reports, Council of Europe, CPT/Inf/E (2002) 1 – Rev. 2010. Available at <http://www.cpt.coe.int/EN/docsstandards.htm> (last accessed on 16 January 2012), p. 35, under "f. Professional independence".

[38] See Ch. 5, § 3.1.

current practices – it is not the prison authorities or the physician who decides on force-feeding, but decision-making is delegated to an impartial and independent judge. This judge performs a substantial review of all the interests at stake when reviewing whether the exception from the basic rule that no intervention is allowed in a competent prisoner on hunger strike may be applied. In this, he will take the prisoner's right to refuse food as a starting point. Unlike the prison authorities, who bear the risk of being influenced by politics, considerations of maintaining order and security inside the prison or other interests and may be heedless of the prisoner's interests, the judge will take the prisoner's rights and interests in full consideration and will balance them against the interests of preserving the life of the hunger striker until a verdict in the trial has been reached. As stated earlier, if the judge declares force-feeding admissible, he only provides legitimisation to the treating physician to act against the prisoner's wishes, and does not oblige the physician to apply force-feeding. In this way, the physician remains free to choose whether, and if so when and how, he will apply force-feeding to the hunger striker. In this way, the physician can operate with complete independence within the bounds of his qualifications and competence, and he is an arm of neither the politicians nor the authorities.[39]

Because of this, in my opinion, a judge's authorisation for the physician to act against the prisoner's wishes is very different from a concurrent decision by the prison authorities or other third parties, and therefore far more likely to be followed by a physician.

Besides, the WMA Declaration of Malta always regards force-feeding as a form of inhuman or degrading treatment, while in my opinion in the proposed exception it is not, since the force-feeding takes place under the conditions as prescribed by the ECtHR and CPT.

It can be concluded that, despite their authoritative status in the treatment of hunger strikers, and the many valuable aspects contained in the WMA Declarations on the treatment of hunger strikers, deviation of the principle of absolute respect for the hunger striker's decision to refuse as illustrated there can be justified when intervention is declared permissible by a judge. The physician must notify the hunger striker of his willingness to apply force-feeding; it must be clear to the prisoner whether his physician is in fact willing to apply the force-feeding if intervention is declared permissible by the judge. If a physician indicates that he is not willing to apply force-feeding after a judge will or has allowed him to do so, he may not be threatened with criminal or disciplinary action. Nevertheless, the prison authorities are free to look for another physician who is willing to apply force-feeding.

[39] This is in accordance with the CPT, who stated that "the management of hunger strikers should be based on a doctor/patient relationship", and expressed "considerable reservations as regards attempts to impinge upon that relationship by imposing on doctors managing hunger strikers a particular method of treatment". Visit to Turkey, in 2000 (December) and 2001 (May), CPT/Inf (2001) 31, at 33.

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